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GOVERNMENT OF KARNATAKA

NATIONAL RURAL HEALTH MISSION

PROGRAMME IMPLEMENTATION PLAN

FOR THE YEAR 2008 - 09

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FOREWORD

National Rural Health Mission is being implemented in the State of Karnataka since April 2005. The state has been trying to achieve the goals of the Mission which is to provide accessible, affordable and quality health care to the rural population especially the vulnerable sections. It also seeks to reduce MMR, IMR and TFR by the end of 2012.

Karnataka's vision of emerging health service delivery system as per State Health Policy is to provide quality services with equity, transparency and accountability at all levels with a strategy of primary health care approach and through engaging service of health providers.

The key features of the implementation of NRHM in the state includes making public health delivery system fully functional and accountable to the community, working in a Mission mode, Decentralized Planning, Delegation of Powers, Human Resource Management, Community Involvement, rigorous Monitoring and Evaluation against standards, Convergence of health related programmes and Flexible Financing.

A State specific Programme Implementation Plan for NRHM for the year 2008-09 has been developed by integrating District Health Action Plans from all the 27 districts in the state. It is based on the district specific health needs and comprises of all the components of NRHM .It presents the unique features, specific problems and strategic interventions to address them. An attempt has been made to project health initiatives of State sector and KHSRDP.

I take this opportunity to thank the Government of India for its support and guidance in this regard.

M. MADAN GOPAL I.A.S

Date: 28th March 2008
Bangalore

ACKNOWLEDGEMENT

I am thankful to the Ministry of Health and Family Welfare Services, Government of India for initiating National Rural Health Mission in the State.

National Rural Health Mission Programme Implementation Plan for the State of Karnataka has been formulated under the kind guidance of Secretary, Health and Family Welfare Department, Government of Karnataka.

The efforts of Commissioner, H&FWS, Project Administrator, KHSRDP, Director H&FWS, Director of SIHFW, Project Directors of RCH and IDSP, Programme Officers of all National Health programmes and SPMU and Consultants of Directorate and District Health and Family Welfare Officers, District programme officers and DPMs who were involved in the preparation of the PIP is very much appreciated.

The Government of Karnataka has always extended support to the Programmes initiated by the Government of India and followed the National Health Policy guidelines in the implementation.

I earnestly hope that the Programme Implementation Plan for the year 2008-09 would meet the needs and aspirations of the people of the state and come up to the expectations of Government of India.

NILAYA MITASH I.A.S
Mission Director
NRHM
Government of Karnataka

Date: 28th March 2008
Bangalore

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EXECUTIVE SUMMARY

The Government of Karnataka is committed to enhance the health status of its population with strong focus on improving health outcomes especially among women, children and vulnerable populations such as Scheduled castes, Scheduled tribes and tribal groups. The Karnataka state health policy also provides a framework for realizing this vision. The State has constituted specific strategies and actions required for achieving the goals set under NRHM in its State Health Action Plan.

State Action Plan is a consolidation of District Action Plans prepared by 27 districts. The Activities proposed to be undertaken under various programmes is based on the district specific needs. Such as special focus on backward districts as identified by Dr. Nanjundappa committee, prevalence of the health problem in a given area, improving infrastructure, manpower strengthening, timely distribution of drugs and equipments needed for the facilities. Importance has been given to Programme management, flexible financing, capacity building of members of VHSCs, M&E, and scope for wider community participation through intersectoral convergence.

The programme implementation plan gives a brief introduction to the health status in the state, background information about the state, followed by situational analysis both in terms of infrastructure and health indicators as assessed by different studies. Plan highlights the goals, objectives, strategies and activities drawn up to meet the goals. It also explains the priorities, constraints and actions to overcome the constraints as envisaged in the district action plans.

Hither to experiences with regard to implementation of various programmes like RCH-I and RCH-II during 05- 07, IDSP, RNTCP, NBCP, NLEP etc have been included in the PIP.

0.1 Infrastructure strengthening which includes construction of buildings for various facilities proposed to be undertaken under NRHM, State Sector and KHSDRP has been detailed in the chapter No.1

0.2 Chapter – 2 contains a brief note on New Interventions under NRHM like upgradation of CHCs, (54 CHCs are taken up for 08-09) to provide EMOc services for mothers and newborn care to children. 20000 VHSCs are functioning in the State and their functioning will be strengthened through capacity building of the members of VHSCs. Modules for training is developed. Untied grants for SCs, PHCs and CHCs and maintenance grants for these facilities are required. Arogya Raksha Samitis are formed in the DHs, CHCs and PHCs in the state. 11200 ASHAs who were selected during 06-07 from the tribal districts and 6 backward districts will be trained and placed in the field during 08-09. In the remaining districts 26,800 link workers will be selected.

0.3 Part A of NRHM that is RCH-II programme is detailed in the chapter 3. The main focus is to achieve the set goals with regard to MMR, IMR, TFR. These goals are slightly modified into achievable ones. Interventions related to MCH, ARSH & Family Welfare have been backed by new strategies like institutional strengthening, manpower development, capacity building, incentives to beneficiaries under different schemes, like Chiranjeevi Yojana, Madilu, Prasuthi Araike (post natal assistance for SC/ST mothers belonging to BPL families - State initiative), JSY with special focus on vulnerable population. Providing better health care services to the rural community is the main agenda. This is planned through making PHCs 24x7, and up-gradation of CHCs, to IPHS standards. IMNCI (HBNCI & FBNCI) takes care of critical care needed in the neo natal period. Adolescents especially vulnerable population ie. Tribals, SCs/STs, and out of school children will be given Adolescent health care services through Teen clinics which will be established in the PHCs and CHCs and will be implemented in 8 districts during the current year. Special emphasis is laid on male participation in the family welfare activities. Family planning programme will be intensified with special emphasis on NSV. Forming separate cell to monitor and supervise the implementation of PNDT Act in the state will strengthen provisions of PC&PNDT Act. Quality Assurance programme will be continued as pilot project in one district in the state.

0.4 Part C of NRHM ie. Immunisation programme is narrated in the Chapter 4. The state goal of achieving 100% coverage will be ensured through interventions like alternate vaccine delivery system, strengthening services in the unmet areas, involving social mobilizes, mobility support to DIOs etc. Routine Immunization will be strengthened and regular catch up sessions are planned.

0.5 Part D explains various National Disease control programmes like Integrated Disease Surveillance Programme, National Blindness Control Programme, National Vector Bourne Disease Control Programme, National Iodine Difficiency Disorders Control Programme, Revised National Tuberculosis Control Programme, National Programme on Prevention and Control of Deafness and National Leprosy Elimination Programme.- Chapter 5.

0.6 Part E deals with Inter-sectoral convergence in the chapter – 6. This explains the various activities chalked out at grass root level for the PRIs role in the VH&SCs, ARS, and selection of ASHAs etc. Merger of programmes of RDPR, Education, WCD departments will be ensured through inter sectoral convergence.

0.7 Chapter 7 focuses on Innovations like:
Madilu- a postnatal kit being given to BPL and SC and ST mothers immediately after delivery.

Yashaswini / insurance coverage for very high risk ANC cases and

School health programme is covered under Arogya Chaitanya programme. Health check up will be done for children studying in government schools. Under NRHM it is proposed to help those children who need corrective surgeries.

0.8 Summary Budget under NRHM is given in the Chapter 8.

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1. INTRODUCTION

Karnataka has the unique distinction of creating an independent Task Force to comprehensively review the state health systems and suggest appropriate policies and strategies for improving service delivery, strengthening stewardship, role of the government and empowering users. The Government of Karnataka has accepted the report of the Task Force and initiated actions to implement its recommendations. Support from the World Bank was sought towards this initiative.

1. 1. Health gains

a) During the past century and particularly after independence in 1947, several gains have been made in health and health care in Karnataka. Smallpox has been eradicated. The state has become free of plague and more recently of guinea worm infection. The total fertility rate has come down from 6 in 1951 to 2.10 in 2001.

A brief picture of the health gains is depicted below.

HEALTH INDICATOR		1951	1971	1981	1991	2001
Life expectancy at birth (in years)*	Male	37.15	50.9	55.4	58.1	65.6
	Female	36.15	50.2	55.7	58.6	66.6
Crude Birth Rate (per 1000 population)*		40.8	31.7	28.3	26.9	22.2
Crude Death Rate (per 1000 population)*		25.1	12.1	9.1	9	7.6
IMR (per 1000 live births)*		148	95	69	77	58

*SRS report

1.2 Comparison of Key Indicators for Karnataka Vs India.

Karnataka compares favorably with the National Average in certain key health and demographic indicators.

	Crude Birth Rate			Crude Death Rate			Infant Mortality Rate		
	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban
India	23.8	25.6	19.1	7.6	8.1	6.0	58	64	40
Karnataka	20.6	22.1	17.9	7.1	7.9	5.6	50	54	39

Source: SRS-2005

1.3. Health Inequalities:

The Dr. Nanjundappa Committee i.e., High Power Committee for Redressal of Regional Imbalances (HPC-FRRI) 2001 report has highlighted the regional disparities in health infrastructure and service facilities especially between South Karnataka and North Karnataka. The first Karnataka Human Development Report 1999 has also thrown light on the regional disparities in the matter of health status. Some of the important findings of the aforementioned reports are given in the following tables.

	South Karnataka	North Karnataka	State
I. No. of hospital beds (2001) per lakh population	85	61	80
II. No. of doctors (Govt + Private) per lakh population	30	25	28
III. % of habitations with 40 or more LPCD(drinking water)	62	44	56

Source HPC-FRRI 2001.

Region / District/ State	# of Medical institu -tions per lakh popula -tion	# of Govt. Doctors per lakh populat ion *	# of PHCs per lakh population	Health Index	Gender-related Health Index (GHI)	Human Develop-ment Index (HDI)	Gender related Developm ent Index (GDI)
Coastal & Malnad (5 Districts)	7.78	13.6	5.84	0.685	0.689	0.552	0.537
Southern Maidan (8 Districts)	6.07	11.86	5.26	0.647	0.599	0.473	0.451
Northern Maidan (7 Districts)	4.37	10.57	4.01	0.641	0.537	0.433	0.412
Karnataka	**5.24**	**11.00**	**4.64**	**0.654**	**0.546**	**0.47**	**0.451**

* Source: Karnataka Human Development Report 1999.

1.4 Health gaps

However, gaps remain. Large- rural - urban differences remain exemplified by IMR estimates of 65 for rural areas and 25 for urban areas (SRS, 2002). Despite overall improvements in health indicators, inter-district and regional disparities continue. The five districts of Gulbarga Division (Bidar, Koppal, Gulbarga, Raichur, Bellary), with Bijapur and Bagalkote districts of Belgaum division continue to lag behind. Mal-nutrition in under-five children and anemia in women continue to remain unacceptably high. Women's health, mental health and disability care are still relatively neglected. Certain preventable health problems remain more prevalent in certain geographical regions or among particular population groups. Structural reforms, as suggested by the Task Force on Health, have to be ade and more effective management practices imbued with accountability have to be introduced to ensure swift and effective local responses to health problems.

1.5 Karnataka State Integrated Policy:

The "Karnataka State Integrated Health Policy 2004" articulates the state's long-term vision for the health sector. It states that the mission of the Department of Health and Family Welfare, GOK is to provide quality health care with equity, which is responsive to

the needs of the people, and it is guided by the principles of transparency, accountability and community participation.

1.6 Karnataka Health Policy Perspectives and Goals:

1. To provide integrated and comprehensive primary health care.
2. To establish a credible and sustainable referral system.
3. To establish equity in delivery of quality health care.
4. To encourage greater public private partnership in provision of quality health care in order to better serve the underserved areas.
5. To address emerging issues in public health.
6. To strengthen health infrastructure.
7. To develop health human resources.
8. To improve access to safe and quality drugs at affordable prices.
9. To increase access to a system of alternative medicine.

1.7 Public Health Approach and Primary Health Strategy:

The State recognizes the value of practicing public health and primary health care, for the common good of all citizens. It has committed itself to revitalizing these aspects.

Public Health and Primary Health care work in synergy, particularly emphasizing the principles of:

- Inter-sectoral coordination at all levels, specifically at the district and below.
- Community Participation through Panchayat Raj Institutions and other mechanisms and for involvement in decision-making concerning their own health care.
- Equitable distribution of good quality care, and
- Use of appropriate technology for health care.

The primary health care strategy does not focus only on the primary level but also on the secondary and tertiary levels.

Public health recognizes and attempts to address the socio-cultural, socio-economic and demographic factors that affect health status and implementation of health programs.

Karnataka State Health Policy would attempt to ensure adequate availability of personnel with specialization in public health to discharge public health responsibility in the state.

1.8 Equity in health and health care:

Equity will be a key policy thrust encompassing four main parameters namely, region, disadvantaged groups, scheduled castes and tribes, gender and vulnerable groups (street children, elderly).

The following Table throws considerable light on the differences in the levels of infant and child mortality by these background characteristics, in Karnataka.

Background Characteristics	Infant mortality	Child Mortality	Under-Five Mortality
Residence			
Urban	44.1 (37NFHS III)	12.1	55.7
Rural	70.3 (47NFHS III)	27.1	95.5
Mother's education:			
Illiterate	75.4	29.2	103.1
Literate<middle school complete	49.7	17.6	58.8
Middle school complete	31.1	4.3	55.8
High school complete & above	15.7	5.6	43.1
Religion			
Hindu	65.5	24.0	88.0
Muslim	49.5	17.0	65.6
Cast/Tribe			
Schedule caste	69.9	37.4	104.6
Schedule tribe	85.0	38.9	120.6
Other backward class	60.6	18.7	78.2
Other	56.4	14.2	69.8
Standard of living index			
Low	82.2	38.5	117.5
Medium	54.6	13.6	67.5
High	38.6	12.4	50.1
Total	**62.3**	**22.4**	**83.3**

Source: - National Family Health Survey-III (1998-99)

1.9. Further proof of imbalances/ differences in health indicators available from the district-wise indicators reflected in the following table.

District Wise Selected Key Indicators of Karnataka. (in %)

District	Female Literacy	Girls Married below 18 years	Current users of FP method	Birth order 3 & above	Safe Delivery	Complete Immunization	Composite index
Good Performing Districts *							
HASSAN	59.32	15.20	75.10	19.70	69.70	92.80	81.55
SHIMOGA	67.24	16.50	69.30	22.80	83.00	92.90	80.37
KODAGU	72.53	22.00	70.60	18.80	79.40	94.80	80.06
D.KANNADA	77.39	4.50	63.70	32.00	91.50	86.00	78.77
U.KANNADA	68.48	15.00	66.00	27.20	86.10	89.90	76.11
UDUPI	74.02	4.50	63.70	32.00	91.50	86.00	75.97

Average Performing Districts *

MANDYA	51.62	37.00	71.70	26.10	61.90	88.00	75.86
MYSORE	55.81	47.90	65.40	23.90	69.70	92.70	75.70
BANGALORE (R).	78.98	21.05	63.00	16.40	79.10	83.70	75.34
BANGALORE (U)	78.98	37.00	60.10	26.10	90.60	77.00	75.19
CHITRADURGA	54.62	30.05	59.90	34.40	53.80	88.40	73.98
TUMKUR	57.18	27.10	61.30	27.30	63.50	88.00	73.97
DHARWAD	62.20	36.50	61.20	37.40	65.30	74.80	73.03
CHAMARAJA NAGAR	43.02	47.90	65.40	23.90	69.70	92.70	72.18
CHIKMAGLUR	64.47	37.00	71.40	26.10	78.00	83.50	72.13
KOLAR	52.81	33.50	57.10	29.70	59.20	90.60	71.92
GADAG	52.58	36.50	61.20	37.40	65.30	74.80	69.72
BELGAUM	52.53	55.80	61.80	36.70	68.60	64.80	68.75
HAVERI	57.60	36.50	61.20	37.40	65.30	74.80	65.66

Poor Performing Districts *

BELLARY	46.16	44.20	50.40	48.60	54.00	52.60	65.54
DAVANAGERE	58.45	35.50	59.90	34.40	53.80	88.40	65.43
BIJAPUR	46.19	64.80	47.10	43.00	50.10	53.20	62.86
BIDAR	50.01	67.60	50.60	52.90	52.50	50.30	60.55
RAICHUR	36.84	57.10	45.40	52.80	48.00	37.20	58.34
GULBARGA	38.40	47.70	39.20	53.70	47.70	25.30	58.31
BAGALKOT	44.10	64.80	47.10	43.00	50.10	53.20	54.71
KOPPAL	40.76	57.10	45.40	52.80	48.00	37.20	53.09

Source: National Commission on Population, GOI, 2001Note: - *- The classification is based on the composite index.Regional and inter-district disparities would be factored into the mechanisms of allocation of resources.

1.10 Quality of care:

The possibility of the early enactment of the Karnataka Health Care Establishment Bill to ensure acceptable standards of care would be considered as an important step in assuring quality of care.

Besides the above, the following important components have been envisaged as part of the State Integrated Health Policy with short /long term interventions, keeping in view the set of goals to be achieved.

- Multi sectorability and inter-sectoral co-ordination.
- Public, private and voluntary sector partnerships.

- Health financing.
- Health planning.
- Health management and administration.
- Environmental health.
- Nutrition.
- Population stabilization.
- Education for health personnel.
- National Drug Policy.

1.11 Policy components on priority health problems and issues:

- Women's health.
- Child health.
- Communicable / Infectious Diseases (like Japanese Encephalitis, T.B, HIV/AIDS and Vector borne diseases).
- Prevention and control of non-communicable diseases.
- Emergency health services

In conclusion, through the Integrated Health Policy, Karnataka State is placing health high on its agenda. "Health is Wealth" will be translated into action by allocating adequate human and financial resources, by good governance and institutional capacity building. The state will play a role of facilitator in harnessing resources, energies and ideas from the private and voluntary sector. It will work towards equity, integrity and quality in health and health care.

2. PLANNING PROCESS

2.1 A reorientation-training programme was organized at state level for District Health and Family Welfare Officers, RCH officers and DPMs from all the districts. As per the guidelines Districts constituted district level planning team to prepare their plans.

2.2 Consultation workshops were also held at the district level under the chairmanship of DCs /CEOs and at taluk level for the departmental officials, NGO partners, Panchayat members under the chairmanship panchayat presidents at taluks.

2.3 Facility survey was conducted in all the districts as per the formats given in the NRHM guideline book. The data facilitated the district planning teams to formulate facility wise planning. For instance the construction work for Sub Centers were planned for only those that have available land. Services of experts from medical colleges, and NGOs were taken during the planning process.

2.4 At state level a PIP review team under the chairmanship the Mission Director and Project director as member secretary, was constituted to review and make recommendations and to consolidate the district action plans. The team consisted of Programme officers of all National programmes and consultants. The districts were asked to make presentations and their plans were reviewed. Modifications were suggested which were later implemented by the districts.

2.5 State NRHM PIP is a consolidation of all the district plans. Budget allocations to districts are made as per the activities planned by the districts.

3. SITUTATION ANALYSIS:

3.1 GOALS under RCH:

Health Indicators	Current status	2010 GOALS.
MMR (per lakh live birth)	228 (SRS-2001-03)	150
IMR (Per 1000 live birth)	48 (SRS 2006)	30
Institutional deliveries	66.9% (NFHS-3)	85%
Safe Deliveries	71.3% (NFHS 2003)	95%
% of Children Fully Immunized	55% (NFHS-3) 87% (UNICEF 2005)	100%
TFR	2.08 (NFHS-3)	2.0

3.2. Priorities, Constraints and Action to overcome constraints:

Sl. No	Priorities	Constraints	Action to overcome constraints
1	Functional facilities - Establishing fully functional Sub Health Centers / PHCs/ CHCs/Sub Divisional/District Hospitals.	Dilapidated or absent physical infrastructure • Non-availability of doctors/paramedics • Drugs/ vaccines shortages • Dysfunctional equipments • Untimely procurements • Chocked fund flows • Lack of accountability framework • Inflexible financial resources. • No minimum mandatory service provision standards for every facility in place which makes full use of available human and physical resources and no road map to how desirable levels can be achieved	• Infrastructure/equipments • Management support • Streamlined fund flows • Contractual appointment and support for capacity development • Pooling of staff/optimal utilization • Improved MIS • Streamlined procurement • Local level flexibility • Community /PRI/RKS for accountability / M&E • Adopt standard treatment guidelines for each facility and different levels of staffing, and develop road maps to reach desirable levels in a five to seven Year's period.
2	Increasing and improving human resources in rural areas	• Non-availability of doctors • Non-availability of paramedics • Shortage of ANMs/MPWs. • Large jurisdiction and poor monitoring. • No accountability • Lack of any plan for career advancement or for systematic skill up gradation. • No system of appraisal with incentives /disincentives for good/poor performance and governance related problems.	• Local preference • Contractual appointment to a facility for filling short term gaps. • Management of facilities including personnel by PRI Committees. • Train and develop local residents of remote areas with appropriate cadre Structure and incentives. •Multi-skills of doctors / paramedics and continuous skill up gradation • Convergence with AYUSH • Involvement of RMPs. • Partnership with non-State Stakeholders.
3	Accountable health delivery	• Panchayati Raj Institutions / user groups have little say in health system • No village / hamlet level unit of delivery	• Referral chain from hamlet to hospital • Control and management of Health facilities by PRIs

		• No resources for flexible community action	• Budget to be managed by the PRI/User Group • PRI/User Group mandate for action • Untied funds and Household surveys
4	Empowerment for effective decentralization and Flexibility for local action	• Only tied funds • Local initiatives have no role • Centralized management and schematic inflexibility • Lack of mandated functions of PRIs / User Groups • Lack of financial and human resources for local action • Lack of indicators and local health status assessments that can contribute to local planning. • Poor capability to design and plan programmes.	• Untied funds at all levels including local levels with flexibility for innovation. • Increasing Autonomy to SHC/PHC/ CHC/Taluka/ District Hospital along with well monitored quality controls and matched fund flows. • Hospital Management Committees • Evolving diverse appropriate PRI / User framework • PRI/User group action at Village / GP / Block and District level
5	Reducing maternal and child deaths and population stabilization	• Lack of 24X7 facilities for safe deliveries. • Lack of facilities with for emergency obstetric care. • Unsatisfactory access and utilization of skilled assistance at birth • Lack of equity/sensitivity in family welfare services/ counseling. • Non-availability of Specialists for anesthesia, obstetric care, pediatric care, etc. • No system of new born care with adequate referral support. • Lack of referral transport systems. • Need for universalization of ICDS services and universal access to good quality antenatal care. • Need for linkage with parallel improvement efforts in social and gender equity dimensions.	• Functional public health system including CHCs as FRUs, PHC-24X7, SHCs, Taluka/District Hospital • Trained ANM locally recruited • Institutional delivery • Quality services at facility • Expanding facilities capable of providing contraception including Quality sterilization services on a regular basis so as to meet existing demand and unmet needs. • Thrust on Skilled Birth Attendants/ local appointment and training • Training of ASHA • New born care for reducing neo natal mortality; • Active Village Health and Sanitation Committee;

		• Lack of linkages with other dimensions of women's health and women friendliness of public health facilities.	• Training of Panchayat members. • Expanding the ANM work force especially in remote areas and in larger village and semi-urban areas. • Planned synergy of ANM, AWW, ASHA work force and where available with local SHGs and women's committees. • Linkage of all above to the Panchayat committee on health.
6	Action for preventive and promotive health	• Poor emphasis on locally and culturally appropriate health communication efforts. • No community action & household surveys • No action on promoting healthy lifestyles whether it be fighting alcoholism or promoting tobacco control or promoting positive actions like sports/yoga etc. • Weak school health programmes • Absence of Health counseling/early detection. • Compartmentalized IEC of every scheme	• Untied funds for local action • Convergence with other departments/institutions • IEC Training and capability building • Working together with ICDS/TSC/ CRSP/SSA/ MDM • Improved School Health Programmes • Common approach to IEC for health • Involvement of PRIs in health. • Oral hygiene movement.
7	Disease Surveillance	• Vertical programmes for communicable diseases • No integrated / coordinated action for disease surveillance at various levels in place yet. • No periodic data collection and analysis and no district and block specific epidemiological data available	• Horizontal integration of programmes through VH&SC, SHC, PHC, CHC. • Initiation and Integration of IDSP at all levels. • Building district / Sub district level Epidemiological capabilities.
8	Forging hamlet to hospital linkage for curative services	• Entitlements of households not defined • No community worker • No well defined functional Referral/transport/communication system. •No institutionalized feedback mechanism to referring ASHA/ peripheral health facility in place	• ASHA/AWW/ANM • Household /facility surveys/survey of non – governmental providers for entitlements. • Linkages with SHC / PHC/ CHC for referral services

9	Health Information System.	• Absence of a Health Information System facilitating smooth flow of information. • Not possible to make informed choices	• A fully functional two way communication system leading to effective decision making. • Publication of State and District Public Reports on Health.
10	Planning and monitoring with community ownership	No local planning, no household surveys, no Village Health Registers. Lack of involvement of local community, PRI, RKS, NGOs in monitoring of public health institutions like SHC/PHC/ CHC/Taluka/District Hospitals.	Habitation/village based household surveys and Facility Surveys as the basis for local action. Untied resources for planning and monitoring. Management of health facilities by the PRIs. Thrust on community monitoring, NGO involvement, PRI action, etc. Ensure Equity & Health. Promote education of women SC/ST & other vulnerable groups.
11	Work towards women's empowerment and securing entitlements of SCs /STs /OBCs /Minorities	Standard package of interventions under current schemes. Coverage and quality of services to women, SCs/STs/OBCs/ Minorities not tracked health institution wise. No analysis of access to services and its quality.	Facility and household services to generate useful data for disaggregated monitoring of services to special categories. NGO and research institution involvement in Facility surveys to ensure focus on quality services for the poor. Visits by ASHAs. Outreach services by Mobile Clinics.
12	Convergence of programme for combating/preventing HIV/AIDS, chronic Diseases, malnutrition, providing safe drinking water etc. with community support.	• Vertical implementation of programme. • Only curative care. • Inadequate service delivery. • Non-involvement of community.	• Convergence of programmes. • Preventive care. • Health & Education • Empowering Communities. • Providing functional health facility [SHC], PHC [CHC] for effective intervention.
13	Chronic disease burden.	• Double disease burden. • Lack of stress on preventive health. • Lack of integration of programmes with main health programmes. • No IEC/advocacy. • Inadequate Policy interventions.	• Village to National level integration. • Stress on preventive Health • IEC/Advocacy • Help of NGOs • Policy measures.

CHAPTER - 1

A. Infrastructure strengthening:

(Total budget under NRHM=Rs. 5473.58 lakhs- chapter 8)

Construction and repair work of various facilities proposed to be undertaken under NRHM, State and KHSDRP.

- 2893 Sub centers do not have buildings. Hence it is planned to provide monthly rent of Rs. 500/- under NRHM as this would encourage ANMs to stay in the HQ. Total cost would be Rs.173.58/- lakhs.
- 516 Primary Health Units are upgraded to PHCs in the state. Out of these 10 PHCs @ Rs.50 lakhs per PHC are to be upgraded by the state and 2 will be taken up under NRHM during 2008-09. For this Rs.100/- lakhs is sought from NRHM.
- Construction of PHCs: Construction of 2 PHCs is proposed under NRHM for 2008-09.
- One taluka hospital in backward talukas identified by Dr. najundappa committee is taken up under state budget for Rs.500/- lakhs.
- Seven District Hospitals will be upgraded to IPHS. For this cost of equipment is budgeted under NRHM.
- Construction of 44 CHCs and 53 Taluk hospitals will be taken up by the state at the cost of Rs. 6501/- lakhs.
- EMRI centers would be set up in the state Rs.500/- lakhs is proposed under NRHM.

B. Man Power:

(Total cost= Rs.989.80 lakhs- under NRHM & Rs.4026.78 lakhs under RCH-II- chapter 8)

Different categories of manpower are being recruited under NRHM flexi pool and RCH-11 flexi pool on contract basis. This would strengthen programme management units at state district and block levels and facilitate the state to provide better health services to the rural mass.

- Appointment of ANMs for SCs: 1744 ANMs are proposed to be recruited in the SCs where there are no ANMs positioned. Since there is a shortage of trained ANMs available in the state efforts will be made to recruit Retd. ANMs and ANMs passed out from private ANM schools.
- Recruitment of 1500-second ANMs/staff nurses is proposed under RCH-II flexi pool at sub centers in 6 C category districts.
- 100 Medical officers will be continued on contract in most backward districts of the state.
- 1308 staff nurses will be appointed on contract to 746 PHCs (most & more backward talukas spread all over the state) based on actual need.
- 440 Staff nurses are to be appointed in the CHCs (2 S/Ns per CHC), including those working in 2007-08, which have been upgraded as per IPHS standards.

- 108 lab technicians will be continued on contract to all the CHCs, which will be upgraded as FRUs.
- Under the Janani Suraksha Vahini, an ambulance service vehicle which will be stationed at taluka hospital 2 drivers per vehicle will be continued on contract to provide services to the needy round the clock.
- The SPMU has been set up..
- The DPMUs are functioning in 26 districts of the State.
- Block level programme managers will be set up at all 176 taluks in the state to facilitate the implementation of NRHM activities.
- State NGO coordinator and State level consultants under RCH-II are working
- Hospital management specialists for 6 district hospitals and 6 Public health specialists are proposed to assist District Health and Family Welfare officers and District surgeons to bring in efficiency in management, administration and monitoring.

C. Drugs:

(Total = 1700 lakhs under RCH Additionalities - chapter 8)

- Rs. 1000 lakhs worth sub center drugs is proposed under NRHM
- IFA tablets will be distributed to 2400 lakh ANC cases at the cost of Rs.440/- lakhs.
- IFA tablets (small) will be distributed to the children at the cost of Rs. 100/- lakhs.
- Vitamin A drops will be given to children along with measles at the cost of Rs. 160/- lakhs.

D. Equipments:

(Total Rs. 539.35 under RCH and 1.80 under NRHM - chapter 8)

- Manual Vacuum Aspiration syringes for MTP would be procured under NRHM. 323 CHCs will be given 2 syringes each.
- Sub center equipments / logistics worth 380 lakhs to be procured under NRHM. (details under RCH)
- IUD kits is proposed to be procured

CHAPTER - 2

2.1 NEW INTERVENTIONS UNDER NRHM

(Budget details in chapter 8)

Sl. No.	Activities	Processes
1	Visioning workshops for State, District and Block Level mission Teams	Activity taken up under BCC action plan
2	Orientation of members of PRIs/ community leaders on Village Health and Sanitation Committees, NGOs	Activity taken up under BCC plan
3	Untied grants to Village Health and Sanitation Committees- Every village with a population of upto 1500 to get an annual untied grant of up to Rs.10,000, after constitution and orientation of Village Health and Sanitation Committees revolving fund etc-	Already VH & SCs have been formed in Villages as per the norms. The untied grant to be used for household surveys, health camps, sanitation drives, Capacity building programme is planned for all themembers of 20,000 VHSCs. To accelerate institutional deliveries every VHSC will be given motivational charges to promote institutional delivery @ Rs.50/- per delivery.
4	Selection and training of Community health Worker (ASHA / AWW)	The process of selection of ASHA in 9 Districts is complete and training programme has started.
5	Performance related incentives for AWW (Link Worker) @ Rs 5,000/ Gram Panchayat . Rs.5,000 permanent advance may be made available to every Gram Panchayat as a permanent advance. Disbursement as per performance norms.	Wherever scheme of ASHA / Link worker is being implemented the guidelines will be followed.
6	Madilu	Post natal kits to BPL/SC/ST mothers for delivery in govt. hospitals.
7	Prasuthi Araike	Cash incentive and Saree to SC/ST among BPL during ANC& PNC period under State sector
8	Chiranjeevi yojana	Out sourcing of deliveries to private institutions in tribal and backward districts.
9	Health insurance scheme for the poor	Total budget Rs.4000/- lakhs
10	Untied fund for SCs for local health activity- Rs 10,000/ SC	Total – 8143

Sl. No.	Activities	Processes
11	Untied fund for PHCs for local health activity- Rs 25,000/ PHC	Total – 2195
12	Untied fund for CHCs for local health activity- Rs 50,000/ CHC	Total – 325
13	Rogi Kalyan Samitis for PHCs Rs. 1 Lakh	2195
14	Rogi Kalyan Samitis for CHCs Rs. 1 Lakh	325
15	Rogi Kalyan Samitis for DH Rs. 5 Lakh	24
16	Untied fund for District Health Action Plan- for surveys, workshops, studies, consultations, orientation in the process of preparation of District Health Action Plan- Rs 5 lakhs / annum / district	Will be utilized from district untied fund
17	Telemedicine	Telemedicine facility will be provided at specialists camps planned to be organized at 176 taluks every month to provide specialists services to the rural mass. Telemedicine will help to seek consultations with super specialists.

2.2 Mainstreaming of AYUSH under NRHM:

One of the main strategies of NRHM is mainstreaming of AYUSH. As a part of this strategy, it is proposed to appoint AYUSH doctors in single doctor PHCs as a second additional doctor to provide 24 x 7 service. 275 AYUSH doctors are working against MBBS doctors in Karnataka. The Salary is met out from State.

399 PHCs were identified from 39 most back ward talukas from 13 districts of the state as per Nanjundappa's report as 24x7 PHCs under NRHM programme during the year 2006-07. Out of this 331 PHCs are single doctor PHCs. These 399 PHCs are taken up for strengthening MCH services, by providing additional doctors / staff nurse /ANMs. Necessary drugs and kits are also provided to these PHCs on priority basis during the year 2006-07. At present 314 Ayush doctors are working.

During the year 2007-08, Out of 347 PHCs 253 single doctor PHCs were identified from 40 more backwards talukas from 20 districts as per Dr. Nanjundappa report of the state as 24x7 service under NRHM programme. At present 107 doctors are working, the appointment of other doctors is under process.

AYUSH doctors are appointed on a consolidated salary of of Rs.11,300/- per month and expenditure will be met out from NRHM funds.

I . SALARY COMPONENT :

Ayush Doctors appointed during 2006-07	331
Ayush Doctors appointed during 2007-08	253
Total:	**584**

Monthly consolidated salary for AYUSH Doctors is Rs.11,300/- p.m. Rs.11300 x 12 x584 = 791.90 lakhs

II. DRUG COMPONENT:

Drugs required for AYUSH Doctors at 584 PHCs + AYUSH doctors working against MBBS doctors at 275 PHC @ the rate of Rs. 28,000/- pa.

Therefore the drugs required: 584 + 275 = 859 hospitals.
Rs.28,000 x 859 P.H.C = Rs. 240.52 lakhs

BUDGET

Total Budget for Salary	: Rs. 791.90 lakhs
Total budget for Drugs	: Rs. 240.52 lakhs
Total budget for 2008-09	**: Rs. 1032.42 lakhs**

2.3 MOBILE MEDICAL UNIT

2.3.1. INTRODUCTION:

Access to health care and equitable distribution of health services are the fundamental requirements for achieving Millennium Development Goals and the goals set under the National Rural Health Mission (NRHM) launched by the Government of India in April 2005. Many areas in the country predominantly tribal and hilly areas, even in well developed states lack basic health care infrastructure limiting access to health services at present. Over the years, various initiatives have been taken to overcome this difficulty with varied results. Taking health care to the doorsteps is the principle behind this initiative and is intended to reach underserved areas. Under the NRHM, provisions of Mobile Medical Unit (MMU) in each district is one of the strategies to improve access. In Karnataka MMU is proposed to be taken up in 26 districts except Bangalore Urban.

2.3.2. Objectives:

- To operationalize mobile medical units in every district across the state for improved access to health care services.
- To make health care services available in underserved areas.

2.3.3. Types of services to be provided:

- Every Mobile Medical Unit has to provide preventive and Curative services, like: Treatment of minor ailments, Referral of complicated cases, Early detection of TB, Malaria, Leprosy, and other locally endemic/communicable diseases and non-communicable diseases such as hypertension, diabetes and cataract etc.

Reproductive and Child Health Services:

- Ante-natal check up and related services eg., injection tetanus toxoid, iron and folic acid tablets, basic laboratory tests such as haemoglobin, urine, sugar and albumin and referral for other tests as may be required.
- Referral for complicated pregnancies
- Promotion of institutional delivery
- Post-natal check up
- Immunization clinics (to be coordinated with local sub centers, PHCs)
- Treatment of common childhood illness such as diarrhoea, ARI/Pneumonia, complication of Measles etc.
- Adolescents care such as lifestyle education, counseling, treatment of minor ailments and anemia etc.

Family planning services:

- Counselling for spacing and permanent method
- Distribution of Nirodh, Oral contraceptives, emergency contraceptives
- IUD insertion

Diagnostic:

- Investigation facilities like hemoglobin, urine examination for sugar and albumin;
- Smear for malaria and vaginal smear for trichomonas;
- Screening of breast cancer, cervical cancer etc.
- Emergency services and care in times of disasters / epidemics / public health emergencies / accidents etc.
- IEC material on health including personal hygiene, proper nutrition, use of tobacco, diseases, PNDT Act, RTI / STI, HIV / AIDS etc.,

2.3.4. Manpower: A team of medical and para-medical staff will be recruited on contract.

Composition of the Team:

- Medical Officers - 1
- Staff Nurse - 1
- Laboratory Technician - 1
- Pharmacist - 1
- Helper - 1
- Drivers - 1

2.3.5. Equipment and Accessories + printing of Attendance, OPD Registers, Lab Register, MLC Register, Referral Register, Log book Vehicles

Equipments:

BP apparatus	Weighing machine
Stethoscope	Thermometer
Stretcher	Oxygen cylinder with accessories
Provision for IV Lines	Sterilizer
Examination table	Artery forceps

Needle holder	Needles
Threads	Dressing bin
BP handle	BP Blade

2.3.6. Drugs:

- Primary Carte Drugs
- Emergency Drugs and 1
- Protocol Drugs used in National Health Programmes

Two vehicles will be provided for the purpose with the NRHM Logo.

Sl. No.	Name of the Districts
1	Ramanagaram
2	Chitradurga
3	Davanagere
4	Kolar
5	Shimoga
6	Tumkur
7	Mysore
8	Mandya
9	Mangalore (DK)
10	Chikmagalur
11	Chamarajnagar
12	Kodagu
13	Hassan

Sl. No.	Name of the Districts
14	Udupi
15	Belgaum
16	Bagalkot
17	Bijapur
18	Dharwad
19	Gadag
20	Haveri
21	Uttara Kannada
22	Gulbarga
23	Koppal
24	Bidar
25	Raichur
26	Bellary

2.3.7. Budget for Each MMU is:

Sl. No.	Particulars	Amount per month In Rs.
1	Costing of Instrument and Stationery	20000.00
2	Man Power	26x10x 50000.00
3	Drugs	26x10x 15000.00
4	POL & maintenance of the vehicle.	26x10x 25000.00
	Miscellaneous	26x10x 10000.00
	Total	**120000.00**

Budget for 26 MMUs is Rs. 312 lakhs.

Cost: Rs. 312.00 lakhs

CHAPTER – 3

REPRODUCTIVE AND CHILD HEALTH PROGRAMME - II

Topics covered:

Budget: **Rs. In lakhs**

F	Part A RCH II programme	RCH flexi pool	NGO division
1	Family Planning	2200.00	
2	JSY	3500.00	
3	Maternal health,	2740.21	
4	Incentive to trained MBBS doctors and TA/DA for MTs for EMOC training and LSAS	78.60	
5	Child health,	300.16	
6	Adolescent Health	40.00	
8	Urban RCH	146.80	
9	Tribal RCH & vulnerable	280.40	
10	Support for Haemophilia patients		
11	PPP - MNGO scheme		160.00
12	Training	903.50	
14	BCC	371.90	
15	M&E	271.05	
16	Quality assurance Programme	48.00	
17	PNDT	34.20	
	Sub Total	**11274.84**	**160.00**

3.1. Maternal Health including JSY

(Costing for each activity at village level, Sub Center level, PHC level, FRU level is detailed in 3.1.6 – budget for maternal health)

3.1.1. Background

a) The National Policy Goals

- To reduce the MMR to less than 90 per lakh live births by the year 2010 (Current level: 407 SRS 1998.540: NFHS II 1998-99)
- To increase the institutional deliveries to >90% by 2010

Karnataka is better placed as far as the maternal health indicators are concerned in comparison to the national indicators. Maternal mortality is considered one of the best indicators of women's health and of the quality and accessibility of the health services. The maternal mortality rate for Karnataka is 2.28 deaths per 1000 live births (SRS 2001-03) as compared to the national level of 3.01 maternal deaths per 1000 live births

Table showing Karnataka's maternal health indicators

Sl. No.	Indicator	Karnataka		
		NFHS-3	NFHS-2	NFHS-1
1	3 Antenatal check ups	79.3%	72.4%	73.5%
2	Consumption of IFA for 90 days	40%	NA	NA
3	Safe deliveries	71.3%	59.1%	46.6%
4	Institutional delivery	66.9%	51.1%	38.4%
5	Post natal are within 2 days of delivery	61%	NA	NA
6	Pregnant women who are anemic	59.5%	48.6%	NA
7	TFR	2.08	2.13	2.85
8	un met need for family planning	10.2	11.5	18.2

Source: NFHS 3

b) Causes of maternal deaths in Karnataka 2006-2007 as per the data received in form -9

Causes	Percentages
APH	5 %
PPH	32 %
Anemia	13 %
PET	12 %
Obstructed labor	2.1%
Peurperal sepsis	6 %
Septic abortion	0.4%
Others	29.4

Source: deaths reported to the department in the form -9

- 37 % of the deaths are because of hemorrhage
- 13 % of the deaths are because of anemia which is aggravated by pregnancy. These death are avoidable as the remedy is simple and effective .The low social status of the women limits their access to economic resources, basic education and their ability to make decisions related to their health and nutrition

3.1.2. Goals for maternal health for Karnataka

Indicators	Current status	2008-09	2009-2010
Reduction in maternal mortality	228 SRS (2001-03)	190	150
Institutional deliveries	67.9%(CNAA) 66.9% NFHS-3	75%	85%
Safe deliveries	71.3% NFHS-3	80%	90%
Reduction in infant motality rate	48 (SRS- 2006)	40	30
Total fertility rate	2.08 NFHS-3	2.04	2.0

3.1.3. OBJECTIVES:

- To increase Safe deliveries to 100 %
- To increase Institutional deliveries to 90%

3.1.4. STRATEGIES:

A. Improving coverage and quality of antenatal care, intra natal care and post natal care
B. Strengthen facilities at the PHCs, SC, CHCs to enable the staff to offer quality services.
C. **Janani Suraksha Yojna :** It will target the pregnant women belonging to the **BPL and SC/ST** in the age group 19 years and above up to first 2 live births.
D. **Madilu scheme** for improving the post natal care and new born care.

3.1.5. ACTIVITIES:

A. Village level "ASHA :

In the first phase it was proposed that 8266 link workers be identified, trained and positioned in 6 "C" category districts- (Bijapur, Bagalkote, Gulbarga, Bidar, Koppal and Raichur) in the State, to act as "Healthcare Resource Persons-of-First-Resort" in health related matters, Under the NRHM 3 Tribal districts were taken up for the ASHA scheme.

It is proposed to extend the link worker scheme to all the districts in a phased manner. In all **38,000 ASHAs/ link workers** will be functioning in the State by 2012. Selection for 11,200 ASHAs/ link workers is completed during 1st phase. And training of these ASHAs/ link workers has been started. During the second phase It is proposed to select about 10,000 link workers in the districts of Belgaum, Dharwad, Haveri, Gadag, Uttara Kannada, Bellary, Kolar.

The details of the ASHA scheme under the NRHM/RCH-II project in Karnataka proposed to be implemented are:

ASHA will create awareness and provide information to the community on determinants of health, counsel women on safe Delivery, Contraception etc., she will mobilize the community and facilitate in accessing health services. She will provide primary medical care and inform about deaths and births in the village. She will promote construction of house hold toilet under Total Sanitation Campaign.

Selection of ASHA-- one worker per 1,000 populations.

Training of the ASHAs/ link workers: The candidates selected will be given training in all preventive healthcare aspects of pregnancy, antenatal care, delivery care, postnatal care, newborn care, neonatal care, diarrhoea, acute respiratory infections, first-aid and treatment of minor ailments The overall organization, monitoring and coordination of the **ASHA** training will be entrusted to a NGOs

Budget for Training ASHA:

The budget for ASHAs/ link worker's training sessions will include cost of Training of Master Trainers, training of trainers, salaries of trainers and coordinators in each district level training institution, to and fro fares for the candidates for coming for the training, boarding cost at the training institution, cost of training material, wage compensation for the candidates for the duration of the training, etc.

In the new implementation framework a provision has been made for an expenditure of Rs 10,000 per ASHA during a financial year. The training is to be planned in this year. The budget for training of 2934 ASHAs in 3 tribal districts and 8266 link workers **in** 6'c Category districts.

Total of 11,200 ASHA's/ link workers @ Rs 10,000 per ASHA

1. **Tribal districts**
   a. Training of 2934 ASHAs = Rs.293 lakhs
   b. Incentives for 2934 ASHAa @ Rs.1000/- pm x 12 = Rs.352 lakhs
   c. ASHA support system = Rs. 126 lahs
   d. Total for ASHAs in tribal districts is 771 lakhs

2. **6 C Category districts**
   a. Training of 8266 link workers= Rs.826 lakhs
   b. Incentives for 8266 link workers @ Rs.1000/- pm x 12 = Rs.992 lakhs
   c. link workers support system = Rs. 211.00 lahs
   d. Total for link workers is 2029 lakhs.

3. **Selection and training of Link workers in 7 districts:**
   a. No. of link workers – 10000
   b. Cost per link worker – Rs.10,000/-
   c. Total cost=10000x10000 =Rs.1000 lakhs

Cost: 771.00 + 2029 +1000 = Rs. 3800 Lakhs

B) At Sub Centre level:

1) Rent facilities to all the sub centers functioning out of rented buildings:

There are 8143 sub centers in the State out of which 4460 run in the government buildings and 790 in rent free panchayat buildings, 2893 SCs are functioning from rented buildings. Hence it is proposed to provide rent for SCs @ Rs. 500 pm for 2893 sub centers without buildings under NRHM flexi pool.:

Cost: Rs. 500x2893x12= Rs 173.6 lakhs will be allotted from the 1st quarter

2) Contractual appointment of ANMs against vacant posts

There are 8143 sub centers in the state. There is a vacancy of 1744 ANMs, considering the Attrition rate, it is proposed to take 1744 ANMs on contract at Rs. 6000 pm. These ANMs will perform all functions done by the regular ANMs.
Retired ANMs or Staff Nurses willing to work as ANM will also be taken of these posts. (600 girls undergoing training at ANM TCs will pass out in August.)

Cost: 1744x6000x12= Rs.**1255.68 lakhs**

3) Additional ANM:

As per IPHS norms for SCs under NRHM scheme, each Sub center should have **2 ANMs.** There are 8143 ANMs in state, which require equal number of ANMs in addition to the regular sanctioned posts. Due to shortage of qualified ANMs, it is not possible to appoint 2nd ANM for all SCs. Hence on a pilot basis it is proposed to appoint on contract basis (from second quarter), Staff Nurses as 2nd ANM to perform clinical work on non-itinery basis at Rs. 6000/- pm. in 1500 sub centers in **6 "C" category** districts (Bagalkot, Bijapur, Bidar, Gulbarga, Raichur and Koppal).

District wise break up of SCs :

SN	Districts	Number of sub centers
1	Bagalkot	224
2	Bijapur	285
3	Bidar	234
4	Gulbarga	378
5	Raichur	196
6	Koppal	183
	Total	**1500**

Cost: Rs. 6,000x1500x9= **Rs.810.00 lakhs**

4) Mobility support

In the State of Karnataka there are 8143 sub centers. One sub center caters to approximately a population of 5,000. The ANMs are the backbone of all the health programs, who apart from managing the sub center clinic have to do field work. The fieldwork entails visiting the villages and the houses for antenatal care, post natal care as well as for immunization. Other important activities like IEC activities for family planning, and all the national health programs require her to travel a minimum distance of 4-5 Kms per day.

The ANM will play an important role in supervision once the ASHAs are recruited. For all the above activities at present there is no provision of vehicle facility for the mobility of the ANMs, this hampers the program. In order to improve the maternal and child health parameters it is essential to provide the ANMs with mobility support.

It is proposed to provide a sum of Rs 200/pm (Rs.50 a week) as mobility support to each ANM at the sub center.

Budget : Rs 200 x 8143 x 12 = 195.43 lakhs

Cost: **Rs 195.43** Lakhs (Under line item in)

5) Untied fund:

Untied funds are provided at the sub centers for local health action. A sum of Rs **10,000 per sub** center per year to be utilized as per the NRHM guidelines

Cost : Rs.10000 x 8143= Rs.8143 lakhs

6) Referral transport: A sum of Rs 200/ is proposed for each case that is referred to higher center This is to be utilized from the un tied funds which are available at the sub center

The expenditure for hiring the transport for referral will be met out of the untied fund available at the rate of Rs **10,000/sub center**.

7) Incentive for ANMs for safe delivery of high-risk pregnancies

If an ANM takes responsibility for follow **up of High risk** pregnant women till she delivers in a hospital (PHC/CHC/District Hospital), she will be paid an incentive of **Rs.250/-**for each delivery. This will ensure a reduction in the maternal and neonatal mortality.

Cost Rs.326 lakhs /- (1, 38,262 x 250).

8) Awards for best performing ANM:

An amount of Rs 5,000 will be cash award to one best performing ANM per Taluka per year. Selected ANMs will be facilitated on World Health Day with the award. It also includes a citation and certificate. This is an incentive for others to get motivated to perform better. The ANMs' performance will be judged by a set of parameters decided by a committee.

Cost: Rs 5000X 176= Rs.8.8 Lakhs.

9) Sub Center Logistics:

a) Hemoglobin estimation, (each book having 100 tests hence for 3 checkups 300 books) 300 books per sub center.
b) Urine test strips 3,000 test strips per sub center.
c) Pregnancy detection kits –3 lakhs
d) SSD Kits-7 lakhs

Cost : Rs. 380 lakhs

10) Drug kits :

Sub center drugs to be supplied includes misoprostol and magsulph besides the KIT-A and Kit B.

Cost: Rs.1000 lakhs

11) A.N.M. Training Institutions:

In the section on contractual ANMs ie to appoint 2nd ANMs per sub center it was said there was shortage of trained ANMs. The reason is shortage of ANMTCs. Hence to overcome this problem additional number of ANM Training Centers would be required.

- There are 19 ANMTCs in 19 districts in the state run by government. Districts formed since 1998 onwards do not have ANM training schools.

It is proposed to start ANM training centers in 10 new districts of Bangalore (Rural), Gadag, Haveri, Bagalkote, Koppla, Davangere, Udipi, Chamrajnagar, Ramanagar and Chikkbalapura.

Running cost of these institutes amounting to 40 lakhs per institute is to be borne out of NRHM funds

Total budget = 300 lakhs (from 2nd quarter)

C) At PHC Level:

It is planned to take up all 1679 PHCs (old) for improving access to Essential Obstetric and Newborn care during Phase II of the RCH Programme.

Service package

The service package will cover

- Organization of ANC clinics in PHCs
- Conduct of normal deliveries
- Identification of complicated deliveries and referring to CEmONC centres
- Attending newborn care and services
- Referring newborn with complications
- Assisting MOs in OP and in Family Welfare operations
- Inserting IUDs
- Referring high-risk cases to FRUs.

1) Contractual Doctors:

For round the clock services at the PHCs it is essential to have at least one MBBS doctor per PHC. As of date there is a vacancy of 498 doctors at the PHCs. 100 Doctors in 6 category districts are continued from 2007-08 at @ Rs 17,000/- per month. The above MBBS doctors recruited could be taken up at the concerned Taluka /CHC hospital also as duty medical officer as per the need to be decided by Taluka medical officer & DHO.

Cost: The total budget would be 204 lakhs.

2) Contractual Staff Nurses:

- In view of increasing the institutional deliveries at the PHCs it is proposed to hire staff nurses on contract.. This intervention was proposed under RCH, so as to have a qualified and trained person for delivery. It should be mandatory for all contractual staff nurses to stay at the headquarters. This intervention has substantially improved the delivery performance in the PHCs and early identification of complicated cases of pregnancy and referral to FRUs for management. These staff nurses are continued in RCH 2 the honorarium has been increased so as to be on par with the regular staff @ Rs 7,000 per month.

- It is planned to take up all the PHCs for improving access to Essential Obstetric and Newborn care during Phase II of the RCH Programme. The selection of PHCs where the staff nurses are to be taken on contract basis will be based on the needs of the PHC.

- The aim of the program is to provide **3 staff nurses atPHC**.
- This is to ensure that each staff nurse's duty is for 8 hours each.
- The PHC should remain open for 24 hours all the 7 days of the week.
- If one staff nurse is already functioning, 2 staff nurses to be appointed,
- If 2 staff nurses are working 1 to be appointed
- If no staff nurses are working all the 3 staff nurses to be appointed.
- The appointment will be on contract basis
- In the State of Karnataka there are 1679 PHCs

1	399 most backward PHCs to have to appoint 2 SNs additional over 1 SN (regular from State)	798
2	347 more backward PHCs to have to appoint 1 SNs additional over 1 SN (regular from State)	347
3	No. of SNs appointed under RCH in 6 C category districts	163
4	Total of 1,2,3, above	1308
5	1066 SNs for gap to convert total of 1187 PHCs to make into 24 x 7	1066
6	Total no. of SNs = 1308 + 1066	2374
A	**Total cost= 2374 x 7000 x 12**	**19,94,16,000**

Cost= Rs. 19,94,160 lakhs

3) Remote area allowance/backward area allowance

Generally staff nurses are not keen in serving in the rural areas. They have to be motivated for taking up jobs in rural PHCs To ensure that the staff stays in the backward areas, it is proposed that in the PHCs of the most backward and more backward Talukas districts (considered as Backward areas in the State), an allowance of Rs 300 / pm for staff nurses and an allowance of Rs 5000/ pm for doctors be given.

The incentive to be given to 3 staff nurses and 3 doctors at each PHC for 746 PHCs. The estimated Budget required is worked out as under:

a) Group A (Doctors):3 doctors @ Rs 5,000 p.m. 2238 Nos (746x3)x12=Rs.1342.8 lakhs

b) Group B (Staff Nurse) 3 staff nurses @ Rs 1000 p.m.2238 (746x3) x12 = Rs. 268.56 lakhs

Cost: Rs. 1342.8 + 268.56 lakhs = Rs1611.36

3A) Assistance to Dais for staying at PHC during night: One dai in 1187 PHCs to be made 24x7 @ Rs.1000/- pm. She will stay at night in the PHC and assist SN while conducting delivery. (She will act as night watchman since SN cannot stay alone at night in the PHC). **Cost: 1000x1187x12=Rs.1424.40 lakhs**

4) Incentives for night deliveries at PHCs :

In order to provide 24 hour delivery services at PHCs, payment of Incentive to the doctor/staff nurse/ and the cleaning personnel @ 200/100/30 per case delivered at night from 8 pm to 7am.The above honorarium will be restricted to 50% of the deliveries conducted at these institutions or actual number of deliveries conducted which ever is less.

In RCH I this incentive helped to increase the night delivery rate by 10% in the 6 backward districts. In order to enhance the rate of institutional deliveries, this incentive is continued and extended to all 1679 PHCs the Total Budget allocation to cover about **1,00,000** cases per year.(Total PHC deliveries for one year-2 lakh, hence 50% of the deliveries is **1,00,000** deliveries)

Cost : 1,00,000 X 330= 330 Lakh

5) Registers & Cards:

ANC cards for all antenatal women including referral, which will be the same for all the districts to maintain uniformity and will be concise, as well as of thicker paper to last all the trimesters, a total of 12 lakh cards per year will be required. **Parturition register, JSY register, ANC register, sub center registers etc**
Total stationary= **100 lakhs**

6) Mobility support at Primary Health Centers:

In the State of Karnataka there are 1679 Primary Health Centers. One Primary Health Center caters approximately to a population of 30,000. Hence a medical officer who is posted at these PHCs has to manage 5-6 sub centers. The medical officer apart from managing the clinic at the PHC has to manage all the national health programs. One of the important job responsibilities of the medical officer at the PHC is supervision of all the national heath programs as also the monitoring of the work turned out by the ANMs, Male health workers, ASHAs and also conducts out reach services in the inaccessible areas.

For the above activities at present there is no vehicle facility for the doctors, this hampers the program. In order to improve the maternal and child health parameters it is essential to provide the doctors with mobility support. It is proposed to provide a sum of Rs 500/pm as mobility support to doctor at the PHC.

Total number of PHCs in the State	1679
Total number of PHCs functioning	1679
Amount proposed for mobility per PHCper month	Rs 500
Budget for 1679 PHCs for one month	Rs 8.39 lakhs
Budget for 1679 PHCs for one year	Rs 100.74 lakhs

Cost : Rs 100.74 lakhs

Monitoring Indicators for 24 hour PHCs

Performance will be monitored on the following indicators

- Number of antenatal clinics conducted
- Number of normal deliveries conducted
- Number of complicated deliveries identified and referred to CEmONC centres
- Number of labour case with "danger signs" identified during process of labour and transported to CEmONC centres
- Number of newborn with complications identified and referred to CEmONC centres
- Number of IUD insertions done
- Number of Family Welfare operations
- Number of emergencies reported outside OP hours attended, given first aid and referred to FRUs

7. Renovation and Maintenance of urban Maternity homes

Many of the peri-urban population seek care in urban maternity homes for the deliveries. Bangalore Mahanagara palike has sufficient funds whereas the other corporations do not have enough funds. Hence it is proposed to give Rs. 50 lakhs as annual maintenance grant to the corporation of Hubli- Dharward which runs a 96 bedded maternity home, This maternity hospital was started in 1857 during the First war of Indian Independence. Hence in remembrance of this great event the health department would like to undertake few repairs and renovations to the hospital. If need arises present building will be demolished and new building will be taken up for construction.

Cost:= Rs. 50 lakh

D) At FRU level:

Emergency Obstetric care:

Establishment of CEmONC Centres by upgrading FRUs to provide 24 hour Emergency Obstetric and Newborn care services

Having carefully considered the issue and taking into account related factors such as delays in treatment on arrival at a health facility, weaknesses in the referral system and social factors hindering access to urgent medical attention for the mother, hence upgradation of CHCs to FRUs is taken up.

1) CHC Up-gradation:

54 CHCs had been taken up for up-gradation to IPHS Standards & conversion to FRUs in 2006-07. On analysis of the situation, it was found that

- 22 were Taluk Hospitals & 32 were CHCs
- Distribution was 2/district without taking into account the no. of Hospitals in each District(Dharwad has only 3 Hospitals while Gulbarga has 30,Belgaum 24)
- Only 14 of these hospitals were performing Cesarean Sections
- Most of these CHCs did not have 4 Doctors in-spite of orders for Contractual appointment of Specialists @Rs.25000 /month.
- None of the Taluk Hospitals with 100 beds & 11 Doctors did not have Blood Storage facilities
- There were 23 hospitals conducting more than 100 Cesareans among these.

- In view of these findings, it was decided to take up Taluka Hospitals as a priority & also provide Quarters where they were not available so as to ensure availability of Specialist in the CHCs even if the cost of upgradation exceeded RS. 20 Lakhs.
- Thus, 56 Taluka Hospitals & 33 CHCs & 1 TH at Sulya which had been proposed in 2006-07 were approved(NRHM) civil works at a cost of Rs. 1961.76 Lakhs.
- Repairs & additional construction was approved for 4 CHCs (2 among the 54 taken up in 2006-07)at a cost of 646 Lakhs
- 40 Taluka Hospitals have been upgraded under various other schemes of the State. The Engineers have been instructed to construct these also according to IPHS Standards & provide room for providing Blood Storage facilities in these buildings also.
- All 54 CHCs upgraded in 2006-07 have been provided with Blood Storage & Neonatal Equipment. The staff of these Hospitals are being given training in Blood storage during January & following this these facilities will be provided license to store Blood. it has been instructed to train Staff Nurses who reside in the Quarters so that they are available at night in an emergency.

It is proposed to take up upgradation of the remaining 37 Taluk Hospitals during 2008-09 @ Rs. 20 lakhs per Hospital.

- 55 taluka hospitals buildings and 34 CHCs have been taken up in January 2008 were upgraded.(37 Taluka level hospitals not taken up by State or NRHM)

Target for 2008-09 for infrastructure = 37 Taluka level hospitals

Cost: Rs.20 Lakhs per CHC x 37 = Rs. 740.00 lakhs

2) Equipment:

- 54 Taluka hospitals are being provided adult and neonatal resuscitation kits, Boyle's apparatus in Feb 2008.
- Blood storage facility: 54 Taluka hospitals mentioned above will be provided blood storage equipment from the budget allotted in 2007-08. An obstetrician and a pediatrician will be on -duty round the clock while an anesthetist will be on call duty.

To ensure quality CEmONC services, the staff nurses from these centres will be trained in labour ward and newborn resuscitation practices, blood bank operations and operation theatre work All hospitals providing emergency obstetric services can hire the services of private anesthetists whenever needed the funds will be provided under RCH II.

In the FRUs blood storage centres will be established. They will function round the clock. The staff to be trained in blood storage.

In 2008-09 : Blood Storage For 40 Institutions(Taluka level upgraded under State in 2007-08)

Cost: @ 2 lakh per unit= Rs.80.00 lakh

3) In the State of Karnataka there is a shortage of specialists for which the following steps are contemplated by the state. The total number of **specialists** required on contract at the districts : **385.** Following elaborate discussion; considering the fact that specialists are not available in certain talukas & there have been no appointments, it was decided to give a lump-sum amount of Rs. 50.000 per CHC to the Dist. Health & FW Officer to use it as can be applicable for those particular CHCs, so as to provide institutional delivery for the local population. – hiring / contractual appointment/ Yashaswini etc., The guidelines would be issued in detail.

Cost :149 x 50,000 x 12 = 894 lakhs

- **Hiring** the services of the **anesthetists** for emergency operations for which they will be paid per case. In those facilities where **gynaecologist**s are not posted their services will also be hired. FOGSI members are also being sensitized and in RCH II their co operation is expected to be better than RCH II. This scheme has been taken up by **KHSRDP**
- **Training of MBBS doctors for Anesthesia and OBG :** Training for anesthetists has commenced and is conducted by the SIHFW
  Training for OBG to be done in collaboration with FOGSI

4) Training of MBBS doctors in the life saving Anesthesia and obstetrics skills

In Karnataka, under RCH-II program, reduction in the maternal mortality rate (MMR) from the present 195 per lakh live births (SRS 98) and IMR 49 per lakh live births (SRS 2004) is the main objective. To meet this objective, it is imperative that focused efforts be made for making the first referral units (FRUs) fully functional.

EmOC at FRUs is one of the important commitment for the saving the life of the pregnant woman. It has not been possible to fully operationalize these FRUs till now due to lack of anesthetist and obstetrician in the prevailing set up. Hence, in this regard, Government of India, after taking legal opinion, has permitted the states to train the MBBS doctors in Obstetrics (16 weeks training) and Anesthesia (18 weeks training) in identified medical colleges.

1. Bangalore Medical College
2. Mysore Medical College
3. VIMS, Bellary
4. KIMS, Hubli
5. Kempegowda Institute of Medical Sciences, Bangalore
6. JNMC, Belgaum

2 faculties from each medical college from the department of Anesthesia have been identified. 192 MBBS doctors have given consent to undergo training (81 for Anesthesia). Orientation Training programme for the faculties of Medical Colleges is completed.

During 2007-08 no. of doctors trained in LSAS is	39
During 2008-09 proposal to train doctors in LSAS is	54
During 2008-09 proposal to train doctors in OBG is	30
Total:	**123**

5) Incentive for trained doctors under LSS in OBG and LSAS

To motivate these trained MBBS doctors, it is proposed to give an incentive of Rs.1000/- per case subject to a maximum of RS.5000/- per month.

Cost: 123x5000x12= Rs.73.80 lakhs

6) TA /DA for MTs:

To train the MBBS doctors in OBG, Bangalore Medical College is recognized as Master Training Institute by FOGSI. 5 master trainers from Bangalore Medical college are trained at CMC, Vellore for 15 days from FOGSI. In turn the five master trainers have to visit District hospitals at Gulbarga, Belgaum, Hassan, Shimoga and Tumkur to monitor the training program. It is proposed to give TA & DA and contingency of Rs.40000/- per month for these master trainers.

Cost: 40000x12= Rs. 4.8 lakhs

7) Contractual staff nurses at the FRUs so as to provide 24 hr delivery services.:

There are 230 CHCs including Taluka hospitals in the State.

1. 2006-07 upgraded FRU's – 54
2. 2007- 08 Upgraded FRU's – 54
3. 2007-08 – FRU's 35 (additional institutions recommended for 2007-08)
4. 2008-09 – 40 CHC's upgraded in State Scheme with new Buildings.
5. 2008-09- 37 Taluka Hospital are to be upgraded.

Hence Total of 220 Institutions 2 Staff nurses at each CHC/Taluka hospital is proposed The honorarium is Rs 7,000 per month..

Cost: 220 FRU's@ 2 Staff Nurses = 440X7000 X12**= Rs. 369.6 lakhs**

8) Lab technician:

Lab technicians are to be appointed on contract at the FRUs at an honorarium of Rs 3,875 per month so as to provide round the clock services for blood storage, for 108 FRUs initially then to be taken up in all the FRUs in a phased manner.

Cost : 108x3875x12= Rs. 50.22 lakhs

9) User charges: User charges have been levied already for ensuring sustainability of the facilities The BPL families are provided treatment free of cost

10) Best doctor award:

An award for Rs. best performing doctor at Rs.10,000 per doctor per district is proposed. The guidelines for selection of the best doctor will be drawn up. The award will also include a certificate and citation

Cost: 10,000x29=2.9 lakhs

11) **Best staff nurse-** Rs 7,500 per staff nurse per district. The guidelines for selection of the best doctor will be drawn up.

Cost: 7,500x29=2.1 lakhs

12) Safe abortion services- MVA

It is estimated that a number of the annual maternal deaths are abortion related. This number could be dramatically reduced with the adoption of simple and safe abortion procedures like manual vacuum aspiration (MVA) In Karnataka there are a total of 517 centres recognized for performing MTPs. Out of this, 346 are by the government and 171 are private institutions.

Objective:

As very basic facilities are available at most of the government centers at the Taluka/CHC/PHCs, hence D&C and EVA are not appropriate methods in these settings.

MVA and medical abortion are alternatives that are both safe and cost effective. WHO recognizes MVA as the best method for treatment of in-complete abortion and as an essential element of care at the first referral level of the health care system. MVA equipment costs less and is easier to process after use. The procedure itself is less painful and does not require anaesthesia and the women recover much faster.

Advantages:

- Safe , simple, effective
- Not dependent on electricity
- Can be performed at PHCs
- No requirement of anesthesia
- Complication rate is low
- Easy to inspect the aspirate

GO to be issued for making the centers as MTP service providers

Training:

SIHFW to give hands on training and to incorporate in the MTP training.

Equipment: The MVA is performed using a syringe that can hold vacuum and appropriate sized canulae (Karmen). The objective of introducing the MVA technique is not to replace the existing methods of termination but to provide an additional method

Procurement:

2 syringes per year per Taluka hospital and **CHCs@ Rs 1200** per syringe

Cost: **1200x2x323=7.752 lakhs**

13) Reproductive tract infections and sexually transmitted infection:

The incidence of reproductive tract infections and sexually transmitted infections are very high especially among the women in the rural areas. According to some area studies the incidence is around 20% to 30% in many parts of the State. They cause considerable morbidity among women and in some conditions they affect the health of the newborn

Present Strategies

To create awareness and generate demand for treatment of these infections, the National AIDS Control Organization (NACO), in close collaboration with the Department has been organizing the Family Health Awareness Campaign every year. During the campaign, detection, management and referral for RTI/STI cases are undertaken. Prevention, early detection and effective management of common reproductive tract infection have been included as an essential component of care to be delivered through the existing primary health care infrastructure.

The Department has provided the necessary drugs for treatment and also inputs to fill the gaps in laboratory support in PHCs/CHCs. However, upgrading the skills of staff through training has lagged behind in most states. Department has co-ordinated with KSAPS for improving the training component.

KSAPS provides the input for diagnosis and management of RTI/STI at and above district level. To strengthen the services for RTI/STI at sub district level, assistance from the government will be provided in the form of training, drug kits, disposable equipment and provision for contracting one laboratory technicians per FRUs. The importance of prevention, early detection and effective treatment of RTI/STI is well recognized by public health experts, practitioners and the public themselves. Syndromic case management and VCTC are the cornerstones for treatment. Most of the infections still respond to the commonly used antibiotics and chemotherapeutic agents. A beginning was made in RCH I but there was insufficient progress in this area and RTI/STI control needs to be given a major thrust in RCH II.

There is no follow up of the cases, and during inter-campaign intervals, no provision exists for detection of new cases and management

Hence the need for establishing a programme for sustained surveillance for referral and management of RTI / STI cases through the network of TH/ CHCs, PHCs.

Strategies in RCH II

Objectives:

- Promote recognition and syndromic treatment for women (and partners) with suspected RTI/STI.
- Strengthen services for diagnosis and treatment of RTI/STI at PHCs, CHCs, FRUs and District hospitals.
- Strengthen linkages and synergy with KSAPS activities.

Strategies:

The initiatives envisioned cover

Community level

- Train and permit ANMs to provide presumptive treatment to cases and their partners for common RTIs/STIs.
- Train AWWs and ASHAs/link workers to identify/refer cases of RTI/STI.
- Promote awareness regarding RTIs/STIs in the community for prevention, early care seeking and treatment.

KSAPS : Strategy:

❖At present 40 institutions, which include general hospitals, Taluka hospitals, District hospitals and medical colleges have functioning RTI/STI clinics.

❖166 CHCs (30 bedded) have been identified by KSAPS and it is proposed to have these functioning STD clinics in the year 2007-08.

❖Training: training has been planned for the MOs, /SN/LHV/ANM/Lab technician through out the State and will be imparted by KSAPS.

Establishment of RTI / STI clinics

It is planned to organise fixed day RTI / STI clinics on in the state to make the RTI / STI treatment facilities available within the reach of the people.

❖It is proposed to make operational STI/RTI clinics at **323 CHCs** in collaboration with KSAPS the list is enclosed

Services Proposed in the RTI / STI Clinics

The following services will be available at these clinics.

- Screening, diagnosis and treatment for RTI / STI problems among women and partners
- Screening women for breast diseases including breast cancer
- Providing basic lab services for RTI / STI diagnosis
- Providing Indian system of medicine treatment facilities for selected RTIs
- Providing counseling services for motivating the partners to take treatment
- Providing facilities for diagnosis of infertility and referral
- Creating awareness on RTI / STI in the community through RCH outreach camps
- Monthly reporting of RTI / STI cases, diagnosed, treated and referred

Budget for 117 CHCs for drugs to be supplied by GOI.

14) Remuneration to ART center to prevent loss to follow up

- There are 16 ART centers
- 8 new centers to be established
- Out of 40,000 patients registered 10% are lost to follow up due to various reasons like loss of wages and cost of transportation and reactions
- It is proposed to give Rs 1000/ per case for ensuring follow up either in the form of bus charge or in any other capacity required.
- For 200 cases per center, hence a total of 2 lakhs per center
- Rs 50 lakhs for 24 centers(Rs 2 lakhs kept for emergency)

15) Opportunistic Infections

- ✶ 565 ICTC centres in State
- ✶ Opportunistic infections common in HIV + patients
- ✶ To provide drugs to treat these infections, a budget for Rs.1000/ICTC=Rs. 5.6 lakhs

16) Post natal care:

On postnatal care, the initiatives are to

- ✠ Ensure post natal contact on days 1 and 7, and then at 6 weeks; these visits will be linked with visits for the neonates –IMNCI

17. Operationalisation of maternal death audit

Background

Maternal death is a death of a woman during pregnancy, delivery and within 42 days of child- birth, irrespective of the site of pregnancy or the duration of pregnancy. Studies have revealed that 75% of the deaths are preventable and interventions to deal with maternal deaths can also reduce the infant deaths. A systematic fact finding mission is therefore required to analyze every maternal death. This is to determine the cause of maternal death which maybe a direct obstetric cause, indirect or a socioeconomic cause. This will assist in adopting corrective and preventive measures in the future. Hence there is a need to adopt a maternal death audit for early reporting, investigating and taking action in all the maternal deaths. From next year, all maternal deaths including late maternal deaths will be audited.

Most of the maternal deaths can be averted even where resources are limited but, in order to do so, the right kind of information is needed in order to base actions. Knowing the statistics on the levels of maternal mortality is not enough - information is needed on the causes and circumstances that have led to maternal deaths so as to initiate corrective measures to avert such deaths. All the DHOs have been instructed to report all the maternal deaths within a week to the State

Maternal death audit

1. **At village level:** Reporting: within 24 hrs by telephone/FAX.
2. **Sub- center**:: If a death occurs in a sub center the concerned ANM will report immediately to the MO PHC within 24 hrs who will in turn report to the DHO. The AWW, ASHAs SHG will also be sensitized to report the maternal deaths immediately.
3. **At PHC level**: The MO PHC will report within 24 hrs to the DHO.

- **Government hospitals / institutions**: The superintendent or the medical officer in charge will report the maternal death to the DHO immediately.
- **Private medical institutions/nursing homes**: The doctor in charge will report immediately to the DHO.
- **During transit:** If a death occurs during transit the ANM/AWW/ASHA will report the death immediately to the MO PHC and the DHO within 24 hrs
- **Urban areas:** If a death occurs at the urban area the ANM will report to the DHO within a 24 hrs.

- **Information to the State:** The DHO is responsible for collection and monthly transmission of information on maternal deaths in the District to the Commissioner of health & family Welfare

4. Action at the State level:

The sate level meeting will be held every quarter to assess the quality of the investigations and ensure follow up action to avert the maternal deaths. There is a gross under reporting of the maternal deaths, 1,100 deaths were reported in 2005-2006.The recent report SRS 2001-03 shows MMR as 228 per lakh live births. In order to improve the recording of maternal deaths, it is proposed to provide cash incentive of Rs 200/ per case to each anganwadi worker/ASHA so that she reports by way of telegram immediately

SN	**Activity**	**Number of cases**	Cost per year
2	Incentive to AWW/ASHA/others Rs 200 per case	1600	3.2 lakhs
		Total	**3.2 lakhs**

Auditing of maternal deaths :

It is proposed that in each district 50% of all the maternal death incidents will be audited by a team consisting of an Obstetrician, specialist from medical department and SPM department, who will visit the identified village and conduct a thorough enquiry and verbal autopsy on the maternal deaths in the presence of relatives.

3	Conducting 3 monthly workshops on maternal death auditing	Rs 100,000 per workshop

Cost : =Rs. 7.2 lakhs

18) Janani Suraksha Yojna

The goals of this Yojana are a reduction in maternal mortality rate and infant mortality rate as well as to increase the institutional deliveries in the BPL and SC/ST families.

It will target the pregnant women belonging to the below poverty line households in the age group 19years and above and up to first 2 live births.

Certification:

a) The BPL card would be the instrument of identification of the beneficiaries.

b) If the BPL card is not issued a certification of the BPL status by the grama panchayat where the income is less than Rs 17,000/ per annum.

Features: The scales of assistance under modified JSY would be as follows It has been modified so as to incorporate within it the cash benefit available under National Maternity Benefit Scheme

Rural area Mothers package(BPL and SC/ST)	
Domiciliary delivery per case for first2 live births	Rs 500 per case
Institutional delivery per case for first 2 live births	Rs 700 per case
LSCS in Private Hospitals	Rs 1500 per case

Cash benefit of Rs 500/ for 2 live births is given to all pregnant women (BPL) after registration and at the time of delivery irrespective of the place of delivery.
Eligible beneficiaries under the scheme who deliver in an institution would get an additional cash benefit of Rs 200/ per delivery(500+200)

Urban areas

Urban area Mothers package(BPLand SC/ST)	
Domiciliary delivery per case for first2 live births	Rs 500 per case
Institutional delivery per case for first 2 live births	Rs 600 per case
LSCS in Private Hospitals	Rs 1500

Total number of JSY beneficiaries expected during 07-08

	Rural area	Urban area
Beneficiaries		
Home-	1.40 Lakh	
Institution	2.24 lakhs	1. lakh (urban)
LSCS		30,000
Total beneficiaries		4.9 lakhs

It is proposed an amount of Rs **200/ to the TBA/ ASHA** for **escorting** the pregnant woman to the institution for delivery, throughout the State.
Total budget for JSY:

- Home-1.40 lakh x Rs 500= Rs.700 Lakhs
- Institution (rural areas): 2.24 lakh xRs.700=1568 Lakhs
- Institution (urban areas): 1 lakh x Rs.600= 600 Lakhs
- LSCS= 30,000 x 1500 x= Rs.450 lakhs
- Escorting=Rs.182 lakhs

Cost: Rs. 3500 lakhs

19) JANANI SURAKSHA VAHINI:

Under Janani SurakshaYojana, a new scheme called Janani Suraksha Vahini was proposed during 2007-08, where in ambulances which are placed in 149 taluka hospitals are provided with two drivers for emergency cases (Pregnant Woman & ChildrenThese ambulances have one driver at present. By appointing two drivers the state will be able to provide 24 x 7 services of Ambulance in all 149 talukas of Karnataka state.

One mobile Phone will be provided for each taluka. The proposed salary component for each driver is Rs.5000/- per month. The total salary component for drivers in 149 talukas will be Rs.5000/- x 2 x 149 x 12 = 179 lakhs per annum.

The recurring cost of each mobile is Rs.100/- per month. The total recurring cost of 149 mobiles is Rs. 1.80 lakhs per annum.

BUDGET

1. Salary component (Drivers) Rs. 179.0 lakhs
2. Recurring cost of Mobile phones Rs. 1.8 lakhs

Cost: Rs.180.80 lakhs

3.1.6. Budget for Maternal health

Rs.in lakhs

Sl No	Component	Unit cost	Total
1	Mobility support at sub center to the ANM so as to conduct out reach sessions of antenatal and immunization	Rs 200 pm for 8143 sub centers	195.44
2	Incentive for ANM's high risk pregnancies	@ Rs 250 per delivery For 1,38,262 cases	326.00
3	ANM award- best ANM award per Taluka	@ Rs 5,000 for 176 Talukas	8.80
4	Remote area allowance for doctors for 746 PHCs(Most & More backward)	For 3 doctors at (2238) @ Rs 5000 pm	1342.80
5	Remote area allowance for staff nurses for 746 PHCs	3 staff nurses (2238) @Rs 1000 pm	268.56
6	Incentive for night delivery at PHCs for 50 % Deliveries at 1679 PHC's.	@ Rs 330 per case for 75,000 cases	330.00
7	Stationery	ANC cards, JSY cards and registers etc	100.00
8	Mobility support for PHC	@ Rs 500 pm for 1679 PHCs	100.74
9	Best doctor award	@ Rs 10,000 per doctor For 29 districts	2.9
10	Best staff nurse award	For 29 districts @ Rs 7,500 per staff nurse	2.175
11	ART(Anti Retro virus treatment)	Rs 1000 per case for ensuring follow up 0 lakh per center for 24 centers(16 ART & 8 new) 2 lakhs for emergency	50.00
12	Opportunistic infection	For 565 ICTC centers @ Rs 2,000 per center	5.6

13	Maternal death audit for reporting of deaths For conducting workshops	Reporting Rs 200 per case for 500 cases Workshops—1 lakh per workshop x 4 division.	7.2
	Total		**3100.23**

Cost Rs.3100.23 reflected under F – RCH –II programme in chapter 8

GOI approval for Rs.2376.00/-

Sl No	Equipment and logistics		Total budget Rs. in lakhs
1	Logistics for sub centers and PHCs	SSD Kits, pregnancy detection kits, urine strips etc	380.00
2	MVA Equipment for MTP for 323 CHCs 2 syringes per CHC	@ Rs 12,00 per syringe	7.752
	Total		**387.75**

Cost: Reflected under D Equipments in Chapter-8

GOI approved for 387.00 lakhs

Sl. No.	Component Human resources	Unit cost	Total budget Rs. in lakhs
1	Training for ASHA+ incentive + resource centre	@ Rs 10,000 per ASHA	**3800.00**
5	ANM for the vacant position which is 1744	@ Rs 6000 pm for 12 months	**1255.68**
6	2nd ANM (8143) For up gradation of sub center to IPHS standards in 6 C category districts	@ Rs 6000 pm 1500 ANMs from 2nd qtr	**810.00**
7	Contractual doctor for the PHCs in the 100 posts	@ Rs 17,000 pm	**204.00**
8	Contractual staff nurses at PHCs	@ Rs.7000/- p m for 1308 SNs and @ Rs,4000/- pm for 1066 SNs	**1610.40**
9	Specialists for 149 Taluka Hospitals.	@ Rs 50,000 per Taluka pm	**894.00**
10	Staff nurses at FRU 2 staff nurses for 220 FRU's	@ Rs.7,000 pm	**369.60**
11	108 Lab tech at FRU's 108 x 12 months	@ 3875 pm	**50.22**
		Total	**8993.90**

Cost: Reflected under B Manpower in Chapter-8

GOI approved for Rs.8605.60 lakhs

3.2 CHILD HEALTH:

(Cost details in 3.2.5 and 3.2.6)

3.2.1. GOALS: for child health

To reduce IMR from present 48 /1000(SRS 2003) live births to 30 by the year 2010

To reduce Neonatal Mortality from 40/ 1000 live births to 25 by the year 2010

To increase exclusive Breast feeding to 90% by 2012

Present Status & Goals

Health Indicators	Current Status NFHS III	Current Status DLHS	Goals		
			2008-09	2010	2012
IMR	43/1000LB 48(SRS)		35/1000LB	30/1000LB	28
Nutrition- under-weight(thin for age)	41%		35%	30%	20%
Fully immunized	55%	85%	100%	100%	100%
Diarrhea taken for treatment	64.8%		80%	90%	100%
Diarrhea treated with ORS	**31%**	**40%**	60%	70%	80%
ARI taken for treatment	78.9%	75.8%	90%	100%	100%
Know about danger signs		**20%**	50%	70%	90%
Breast fed within 1 hour	**35.6%**		60%	80%	90%
Exclusive breast feeds	**58%**	**40%**	60%	80%	90%
Complementary &continued BF	72.5 %		80%	90%	100%
Children under 3 years who are stunted- Short for age	38.%		35%	30%	25%
Children under 3 years who are wasted- thin for height	17.9 %		15%	13%	10%
Children under 3 years who are underweight-thin for age	41.1 %		35%	30%	20%

3.2.2 OBJECTIVES:

a. Safe deliveries to 100 %
b. Institutional deliveries to 90%
c. Ensure early Breast feeding & exclusive Breast feeding for 6 months
d. Complete primary Immunization by age one year to 100%
e. To reduce child malnutrition levels
f. Create awareness for care-seeking in early stages of Pneumonia
g. Promote use of ORS in Diarhoea

3.2.3. STRATEGIES:

a. Immediate care of new-born & identification & referral of High risk new-borns through SBA(Skilled Birth Attendance) Training.

b. 100% immunization including the booster dose
c. Prompt and appropriate community level care for all sick children and neonates
d. Regular House visits and counseling by community level care gives for preventive and promotive health, of children and the reduction of child malnutrition.
e. Strengthening and supervising the subcentres for its routine services esp. immunization.
f. Adequate referral arrangement and secondary care facilities for sending a sick child or neonate when it requires hospitalization.
g. Reducing cost of care especially on inessential and hazardous drugs and therapies so as to favorably impact on poverty levels:

3.2.4 SITUATION ANALYSIS

Component	NFHS I	NFHS II	NFHS III	DLHS
IMR per 1000 live births	65	52	43 (SRS 48)	
IMR URBAN per 1000 live births	60	40	37	
IMR RURAL per 1000 live births	68	57	47	
Nutrition- Children under 3 years who are under-weight(thin for age) %	51%	44%	41%	
. Children under 3 years who are stunted- Short for age %	40%	37%	38%	
Children under 3 years who are wasted- thin for height %	20%	20%	18%	
Children under 3 years who are anemic %	82.7%	79.4%	84.3%	
Fully immunized %	52%	60%	55%	85%
Diarrhea taken for treatment %			64.8%	
Diarrhea treated with ORS %			31%	40%
ARI taken for treatment %			78.9%	75.8%
Know about danger signs %				20%
Breast fed within 1 hour %			35.6%	
Exclusive breast feeds %			58%	40%

- From the above factors, it may be realized that the decrease in IMR has been progressive over the past years. It is observed that the decrease in IMR is slightly higher in the urban areas (38.33%) compared to Rural areas(30.88%). This is expected because of better access to health facilities & better awareness in the Urban population.

The figures of ARI taken for treatment & Diarrhea taken for treatment are quite high, however the figures for knowledge about danger signs of Pneumonia & treating diarrhea with ORS is very low. Similar findings were reported by the Joint Monitoring Teams which visited the districts of Chamarajanagar, Bellary & Chitradurga in December. This is one of the contributory factors for high mortality as the child re aches the hospital during the late stages when he/she would be in the advanced stage of the illness & it would be quite difficult to save the child in-spite of the best efforts.

- The scenario under Nutrition, though it has not shown very great change; it is not very alarming either - one of the indicators that the Anganawadis are performing well. The weight for height is proportional in 80% of children. However, the height & weight for age should also be proportionately improved & this can be achieved through regular monitoring of Growth against Growth Charts.

- Anemia among children below 3 is high indication that we have to look into the aspect of de-worming & supplemental iron & folic acid tablets.

- Hence the focus will be on Preventive & Promotive aspects, which do not necessarily mean costly equipments but BCC. BCC should occur both in the Community & the Health personnel - focus more on the preventive aspects like Early Breast Feeding, use of ORS, information of danger signs & early referral.

- Apart from this, the emphasis on improved Reporting from Districts needs to be addressed. The establishment of HMIS under KHSDRP is one solution. Involvement of medical colleges wherever available in the compilation of reports could be an additional strategy.

3.2.5. ACTIVITIES:

A. Integrated Management of Neo natal and Childhood Illnesses (IMNCI)

- The IMNCI approach will be the centre piece of newborn and child health strategy in RCH II.
- A comprehensive model of IMNCI will be implemented in 5 district i.e, Belgaum, , Uttara Kannada, Dharwar, Haveri & Bagalkot, districts of Karnataka
- In addition to eight districts of Bidar Gulbarga, Bellary, Gadag, Bijapur, Koppal, Chamarajanagar & Kodagu & the pilot district of Raichur implemented in the last two years so as to cover all the Northern districts of Karnataka .

The following analysis of CNAA reports (April-October2007) show - number of the child deaths in the 1-5 years age group :

Belgaum division- 37.78% & Gulbarga division - 28.74% Together they account for 66.53%. Perhaps the comparatively better figures of Gulbarga are because most of the districts have IMNCI activities.

IMNCI approach will include:

A,1. Co-ordination Committee Meeting

A.2. Facility-based outpatient & In-patient care component outlined in B

A.3. Home / community-based component (ANMs and AWWs).

A.4. Training component (explained under Training chapter -)

A.1. Co-ordination Committee Meetings

- To formulate these approaches, the State level committee, which has been constituted in 2006, will meet once a quarter & review the programme & formulate the plan of action periodically. A budget of Rs.25000 / session is proposed for these meetings at a total cost of Rs. 1 lakh.
- District level committees will be formed as per guidelines & they will also meet quarterly at each district & a budget of Rs.2,000 / session for14 districts is proposed for this. Cost Rs.1.12 lakhs

Cost: Rs.. 2.12 Lakhs --

A.2. Facility Based Out patient & In-Patient Component:

- Care at PHC level & CHC level as in Facility based care
- Health system strengthening through upgradation of CHCs to IPHS standards & repairs to PHC s & Sub centres through untied fund is dealt with under NRHM.
- Capacity Building of staff including the anganawadi workers willl be taken up under Training detailed below & also through regular Continued Medical Education proposed in the CHCs which will be explained under Facility based care.

A.3. Home Based care component:

- The Anganwadi workers & ASHAs will be told about the early identification of common childhood illness & treatment of simple illnesses like a simple easy to follow dosage for Paracetamol for fever.
- The community also will be appraised of these & the identification of danger signs & early referral through Village Health & Nutrition days & also through activities at the CHCs which will be outlined under Home based care for all districts outlined in the subsequent chapters.
- Training in IMNCI will be given to the Medical & Para-medical workers of these districts along with supply of necessary training material. Training under IMNCI is focused on applied skill development. Around 50% of training time is spent building skills by *"hands-on training"* involving actual case management and counseling, the remaining 50% is spent in classroom sessions, building theoretical understanding of essential health interventions. The hands-on training is undertaken through clinical training sessions in hospitals and in the community. Physicians spend 6 days in hospital and 1 day in community; workers spend 3 days in hospital and 4 days in community settings.
- A budget of Rs. 6 lakhs is proposed for Stationery @.100/ unit for dissemination of information of the activities in these 14 districts.

Cost: Rs.. 6.00 Lakhs

The 3 districts taken up in 2006-07 have completed all trainings. The districts included in 2007-08 have completed their Physicians' training & are starting the training of paramedical staff now.

Apart from these trainings mentioned above, capacity building will be continued through regular CMEs at the CHCs as mentioned in the Facility based newborn care.

CARE AT BIRTH, Care at birth is linked intimately to maternal care. The underlying principle is that wherever an infant is born she is provided warmth, resuscitation, clean care and exclusive breastfeeding. She is weighed and examined, and if her clinical needs are not manageable at the place of delivery, she is referred and transported to a facility. Newborn care is relatively easy to implement in facilities because of the presence of skilled birth attendants (doctor/ nurse/ ANM/LHV) and an enabling environment. The **Skilled Birth Attendance** Training that is being given enables the health staff to deliver these services in a more effective manner.

In order to provide New-born the two approaches of Facility based NewBorn care & Home Based Newborn Care will be made use of.

IMNCI Cost Rs. 8.12 Lakhs

B. Facility Based Child Care

The Hospitals will be provided with a **New Born Care Corner** in the Labour wards of all Health facilities. It is ensured that every PHC &CHC/TH/DH should be provided with an enclosure in the existing Labour wards with a provision for multiple electrical points & a socket to fix a 200 Watt bulb so as to receive the new-born baby in a warm environment.

At Sub centre level :

- Equipment for conduct of safe deliveries in the form of SSD kits will be supplied to all ANMs. Details have been provided under Maternal Health.
- The ANMs are trained in Skilled Birth Attendance where they are taught about Essential New born Care. Apart from this capacity building through reinforcement of these issues in monthly meetings & the camps at PHCs & CHCs & during visits by the supervisors will be undertaken. They are especially taught resuscitation, safe transport & Kangaroo Mother care.
- Drugs for treatment of early sepsis will be given to the ANM to be used as per her training above.

At PHC level :

- All PHCs will be equipped to conduct safe deliveries
- 1280 PHCs will be provided with Neonatal Resuscitation Equipment consisting of Suction, Ambu Bag, Weighing Machine, etc as specified by UNICEF.399 PHCs belonging to the most backward areas have been provided with Neonatal Resuscitation Equipment during 2006-07. For 08-09 the above equipments will be procured for 1280 PHCs at Rs.6000/set. **Total Rs.76.8 lakhs**
- Capacity Building of Staff:
- All the Staff Nurses & ANMs will be taught the use of Bag & mask in the Skilled Birth Attendance training.

- They are repeatedly reinforced with this knowledge as on job training & through CME at the nearest CHC .
- They are taught to treat infections with Injectable Antibiotics in case of severe illness & the necessary drugs will be supplied through GOI as the indent for 2007-08 & 2008-09 has been placed in August 2007.. Copy of the list of drugs indented is enclosed.

At CHCs & FRUs

- It is proposed to provide 77 Taluka Hospitals will be provided with **Neonatal equipment** as specified by UNICEF. A kit consisting of a Radiant Warmer, Phototherapy Unit, Glucometer , weighing Machine, Resuscitation Equipment (Ambu Bag, Suction Apparatus. The cost of these equipments together amounts to Rs. 840000/unit amounting to a total of **Rs. 64.68 lakhs.**
- Oxygen Concentrator with accessories to will be provided to 127 Taluka Hospitals with Resuscitation equipments. **Cost of this is Rs 101.6 lakhs**.(budgeted under D - Equipment of chapter - 8)
- The District level hospitals can procure equipment as per their need through the ARS.
- A training in Neonatal care was organized for one Doctor & one Staff Nurse in association with National Neonatal Forum, Karnataka Branch in November 2007 funded by UNICEF. It is proposed to continue such activities.
- **A budget of Rs. 10.66** is allotted for **disseminating guidelines** to the CHCs PHCs & Subcentres @Rs. 100/ centre for 10661 facilities.

CARE OF SICK CHILDREN & MALNUTRITION at FRUs

- Sick children will be cared for as outlined in facility based care of new-born.
- Doctors will be trained in management of sick children at PHC level along with early referral.
- Pediatricians will be out-sourced where the posts are vacant
- Untied Funds available at SCs will be made use for transport of sick neonates and children. Ambulances at taluka hospitals will cater to the referral transport needs of sick neonates and children.

Cost: Rs. 152.14 lakhs

C. Home Based Child Care

- As 30 % of deliveries continue to occur at home, the community at large has to be trained in NewBorn care & the concept of TBA & ANM conducting Home deliveries cannot be denied.the SSD kits provided to the ANMs can be used to conduct deliveries in the home setting wherever it is inevitable.
- It is proposed to hold Community Awareness Programmes once in a quarter in the CHCs/schools in CHC area,etc with the pediatrician if available & the Administrative Medical Officer of the CHC who will be responsible to conduct these programmes.

- This will result in the involvement of the Specialists in Community Health & ensure active participation of the Hospitals in National Programme's & preventive & promotive health.
- Participants will include local women leaders, Stree Shakti Groups,NGOs Women & Child Department & Anganawadis. of the PHCs coming under the CHC apart from the main participants who are the Community people.
- The event could be organized on ANC / Immunisation Days before the start of the session. It should be more of a demonstration exercise & an interactive session rather than a lecture.
- Topics could vary as per the season as mentioned in Facility based care.
- Community awareness camps at CHCs . ME –ORS in the first quarter, Breast feeding second quarter(August-Breast feeding week),NewBorn care third quarter,Nutrition fourth quarter or any topic of relevance to that area at that particular time.

- **A budget of Rs. 129.20 lakhs is proposed for these campaigns @ Rs. 10000/session/CHC/quarter**

- **The village Health & Nutrition Days** will continue at **PHC & Subcentre** levels & these would be as used as platforms to educate the community about Home based care of newborns, diarrhea, Respiratory Infections & danger signs along with informing the public of nearest services available (presence of doctors, diseases which can be treated at various levels & emphasizing about which patients HAVE to be taken to Higher Facilities without wasting time) Funding will be by the IEC Department..
- **A budget of RS. 10.66 for stationery** for disseminating guidelines to all health facilities has been proposed @ Rs. 100/Health facility.

Cost: Rs. 139.86 lakhs

D. School Health & Nutrition Programme

- School health check-ups for Government school children is being regularly under-taken. (Detailed under Innovation in Chapter 7)
- Nutrition of school children is being looked after by the WCD and Education Departments under mid-day meal programme
- De-worming tablets & IFA being given to children.

E. Infant & Young Child Feeding

Breast feeding – Early & Exclusive will be advocated so as to achieve 60% this year. Breast feeding week will be observed in all Hospitals. Right composition of Complementary feeds with locally available food & time of introduction will be told at VHSC meetings & Village Health & Nutrition days.

- Care of children below 3 years is being given in collaboration with Women & Child Department through Anganawadis. The problem of underweight & stunted children below 3 years will be addressed by early identification through regular weighing of children & monitoring with Growth charts. The Nutrition department could be

involved with information on use of local foods which can be demonstrated in the campaigns.

F. Control of Acute Respiratory Infections

Acute Respiratory infections are one of the major causes of under 5 mortality in India. Management of Respiratory infections is as per the guidelines under RCH where the Health workers are taught to classify Respiratory Infections as Upper & lower respiratory Tract infections & as mild, moderate & sever illness as per findings of Respiratory rate, Chest in drawing, wheeze, drowsiness, etc.

Home based care for ARI:

Upper respiratory infections & mild lower illness can be treated with Co-trimoxazole, which can be given by the ANM. Drugs are supplied to the Sub-centre for this purpose. The mother can give these drugs at home. ASHA & AWW will ensure compliance of the patient at home. the ANM will visit the house subsequently & follow up regarding progress of the disease, improvement with drug etc. Asha and Anganwadi workers are taught about the danger signs & asked to ensure early referral as soon as they recognize the danger signs.

Facility Based Care for ARI:

Sub centre level –as outlined above; the ANM will examine the child & after ensuring that the child is properly classified; will start the child on medicines as per the dosage prescribed in the guidelines. PHC level- doctors are trained to give antibiotics & other drugs for Respiratory infections CHC level Apart from drugs, Oxygen Concentrator has Nebuliser attachment which will help in the management of Asthma & related conditions.

G. Management of Diarrhoea

Diarrhea is a major cause of death in under 5 children. Recognition of symptoms & signs & Classification of Diarrhoea into No Dehydration, Some Dehydration,& Severe Dehydration will be taught to all the Doctors & para medical personnel through formal & on – job training .

Use of ORS & IV fluids will be taught & the same will be supplied through GOI drugs, which have been indented as per the list enclosed. The same will be ensured under Home-based care also.As mentioned earlier, the activities of CME & community awareness at CHC,PHC & Village Health & Nutrition days will create more awareness of the importance of seeking treatment in the early stages. Drugs for management of Newborn, ARI, and Diarrhoea etc. will be supplied as per indent placed with GOI

3.2.6 BUDGET FOR CHILD HEALTH (Rs. In lakhs)

IMNCI	8.12
Facility based child care	152.14
Home based child care	139.86
TOTAL	**300.16**

GOI approved for 300.00 lakhs

3.3. Family Welfare Programme

The statistics of total sterilization operations for Karnataka show that, there is little progress in vasectomy (NSV) achievement, during 2007-08. While the total number of all sterilization operations stands at 3, 99,166, the total number of NSV done is 865 for the same period. The percentage of male participation in the family welfare programme as regards to total sterilization operations (Tubectomy, Laparoscopic Operations and Vasectomy), is only 0.2%.

District wise physical progress under Vasectomy (NSV) during 2007-08, shows that only Chitradurga district achieved the target of 2% male sterilization over all the sterilization operations performed.

In order to increase the acceptance of male sterilization, attention needs to be given to the following two major factors.

1. Proper and complete information availability to the community and men in particular, counseling and motivation of the men

2. Availability of qualified NSV providers for rendering sterilization services in identified centers.

3.3.1. The following interventions as per the guidelines of Government of India, are incorporated in the PIP for 2008-09.

1. It is proposed to hold one NSV training course in each of the 29 districts during 2008-09, in order to increase availability of NSV providers in each district, by at least 4 MBBS doctors, trained to provide NSV service. Each training course also provides for intensive IEC activity in the district for community awareness about NSV. The budget required for the training course @ Rs 53,000/- per district = Rs 53,000/- x 29 = **Rs 1537000/-**

2. As per new revised compensation scheme which is being implemented in Karnataka for Family planning. A detailed break up compensation package given to BPL,APL&SC,ST is mentioned below:

A break-up of cash money per case is given below:-

Break up of the compensation package	**Vasectomy (ALL) Rs**	**Tubectomy (BPL+SC/ST only) Rs**	**Tubectomy (NonBPL+Non SC/ST only) i.e.APL Rs**
Acceptor	1,100	600	250
Motivator	200	150	150
Drugs And dressings	50	100	100
Surgeon charges	100	75	75
Anaesthetists	0	25	25
Staff nurse	15	15	15

OT Technician/helper	15	15	15
Refreshment	10	10	10
Camp management	10	10	10
Total	**1500**	**1000**	**650**

Total budget requirement for NSV programme in Karnataka during 2008-09
1. **Budget required for 29 NSV training courses(one in each district) =Rs15.37 lakhs**
2. **Total budget required for NSV @ Rs 1500/- per case x 10,000 cases (Including compensation package) for beneficiaries =Rs 150 lakhs**
Total NSV BUDGET REQUIREMENT FOR 08-09 = Rs ,165.37 lakhs

3.3.2. Training Guideline for NSV training course

Duration	5 days
Participants	4 Medical Officers
Male cases	Minimum 10 cases per Trainee
Trainers TA (as per actual expenditure)	Rs. 4,000
Trainers DA (Rs.400 x 5 days)	Rs. 2, 000
4 Trainees TA	Rs. 2,000
4 Trainees DA (Rs.200 x 4P x 5 days)	Rs. 4,000

Supporting staff

@ Rs, 100 x 2 x 4 days	Rs. 800
@ Rs. 50 x 2 x 4 days	Rs. 400
Stationary	Rs 400
Refreshments	Rs. 2,400
Contingency (Medicines for NSV acceptors, etc,.)	Rs. 1,000
Pre-Training advertisements (IEC activities)	*Rs. 29, 000
	Total = Rs. 47,000

Supervision from Government of India (TA &DA)/
Regional Director / State Family Welfare Officer (TA & DA) Rs. 6,000

Total = Rs. 53,000

*1. Rs.10, 000/- installation of permanent hoarding district headquarters' campus
*2. Rs. 10,000/- for publicity of NSV technique in local daily News- papers.
*3. Rs. 9,000/- for printing of handbills, banners etc.,

3.3.3. Action at District level

At the District level an implementation term consisting of District Magistrate, District CMO, District IEC Officer, District NSV Trainer is to be formed. District level workshops of one day duration would be held by the District team with the elected representatives, opinion, leaders, media and other departmental representatives to sensitize them on male participation and in particular NSV and orient them with the implementation strategy. The committee shall fix up responsibility for pre-camp, camp and post-camp.

3.3.4. Action at Block Level.

Each district would hold• ½ day orientation workshops at block level to workout action plan at block level. A working group of 4 members consisting of ANM, Anganawadi Worker, MPW (male), malaria worker / male worker from other departments would be formed for one sub-centre in the rural area and for one ward in an urban area. The block IEC official / Health Supervisory / Anganwadi Supervisor / Malaria Inspector would be the supervisor of the group.

- Prepare a schedule for visits to the homes of the target couple, inform, counsel and motivate the couples for male sterilization and inform them of the camp dates. Each worker would make at least 2 visits to counsel and motivate.
- Make a list of motivated men and inform the block supervisor who would in turn inform the District FW officer.
- The District FW officer would make arrangements of the camp regarding logistics, number of surgeons required for the number of cases motivated etc.
- The camp would be held on a pre determined date at the district hospitals, strictly following the guidelines laid down in the standards on sterilization manual of GOI.

3.3.5. IEC Activities

1. Meetings at District level, Block level, PHC level.
2. House-to-House hand bill distribution.
3. Posters and stickers pasting on public and Govt. vehicles
4. Publication of daily cam activities like place and date in local news paper.
5. Movement of NSV Rath as done in Madhya Pradesh.
6. Publicity in city cable and electronic media
7. Utilizing Mahila Swasthya Sanghs where it exists.
8. Interpersonal Communication through house to house contact of the target couple to provide information and motivate.

3.3.6.Complaint Redressal mechanism

All complaints arising out of the services provided in a camp should be addressed to the district collector who shall set up a complaint Redressal unit as follows:

i. One nodal officer may be nominated by the district magistrate to lot into the complaints received from the clients / family members of the client.

ii. He shall inquire into the complaint and give suitable reply to the complaint

iii. The district collector shall take appropriate action as deemed necessary, if the complaints are found to be true.

3.3.7. Monitoring for quality

At the State Level

The quality Assurance Guideline of GOI has laid down that the district quality Assurance Committee would be responsible for monitoring quality care in all matters related to sterilization. Hence this committee would monitor the quality of care strictly during the camp as per the guidelines., The dates of the camp and performance report of the camp after its completion should be sent to the centre regularly.

National Population Policy Objectives

Immediate objective is to address unmet needs of contraception, health care infrastructure especially in the Empowered Action Group (EAG) States and health personnel and provide integrated service delivery to basic RCH The medium term objective is to bring TFR to the replacement level by 2010 through inter-sectoral coordination.Linkages among the different goals

Indicator	10th Plan Goals (2002-2007)	RCH – II Goals (2005-2010)	National Population Policy 2000 (by 2010)	Millennium Development Goals
Population Growth	16.2% (2001-11)	16.2 % (2001-11)	-	-
Infant Mortality Rate	45/1000	35/1000	30/1000	-
Under 5 years (Mortality Rate)	-	-	-	Reduce by 2/3 from 1990 levels
Maternal Mortality Rate	200/100000	150/100000	100/100000	Reduce by 3/4th by 2015
Couple Protection rate	65%	65%	Meet 100 % needs	-
T F R	2.3	2.2	2.1	-

3.3.8 Alternative Training Methodology in IUCD 380A

Intrauterine contraceptive devise is one of the very effective safe, long term, reversible method of contraception in married women. In India only 1.8% women of Reproductive age group are IUCDs. Despite the fact that the government offers IUCD services free of cost, I still remains under utilized.

One of the main reasons that IUCD is under utilized, in India is that the Health providers lack accurate up to date information about it, the advantages are understated and disadvantages are exaggerated and many myths and misconceptions are present in the

community and among the providers also. The high discontinuation rate if sue to problems related to providers knowledge and skills leading to poor quality of services. So to increase the pool of trained providers, alternative training methodology for insertion of IUCD 380A is taken up in Belgaum district as a pilot project.

The training programmed started in the year 2007. State level trainers are trained at National level and District level TOT completed by August end. The training of MO / SN/ LHVs/ ANMs started in Belgaum district by October. The training methodology is very good and the providers are very motivated after training, the clients are satisfied and IUCD insertion rate has gone up along with IUCD training IEC activities were also taken up. Now it is decided to extend the programme to all districts in the state from April 2008.

Budget required for Family Planning: Rs. 2200.00 lakhs

GOI approved for Rs. Rs.3500.00 lakhs

3.4. Adolescent Reproductive and Sexual Health

3.4.1. Introduction:

Adolescent Reproductive and Sexual Health is an important component of NRHM. Adolescents form nearly 22% of the total population. Adolescents in the age group of 10-14 years form more than 50% of the adolescent population. According to reports females form 47% of them are males 53%. As per 2001 census the sex ratio among adolescents is 880 for 1000 males. The present adverse sex ratio among 0-6 years will affect the future adolescent population. 43% of ever married females are below 18 years even though the legal age at marriage for girls is 18 in our country. Nearly 20% of the 1.5 million girls under 15 are already mothers (Census 2001). Female mortality is higher than males in the age group of 15-24 years and in the age group of 0-9 years. The pervasiveness of discrimination, lower nutritional status, early marriage, complications during pregnancy, and child birth among adolescents are some of the factors responsible for higher female mortality (SRS 99). Maternal mortality of teenage mothers is a matter of grave concern.

Economic compulsions force many adolescents to work. Nearly one of the three in the age group of 15-19 years is working this result in high drop outs in education. Adolescents from rural areas and girls are the disadvantaged sections. 25% of the 15-19 years age group in rural areas and 10% in urban areas are illiterate. Girls account for less than 50% of enrolment figures in schools and dropout rates from class 1-10 is around 70%. Malnutrition and anaemia is rampant among adolescents. More than 70% of the girls in the age group of 10-19 years suffer from severe or moderate anaemia (DLHS RCH 2004). Adolescent mothers are at a higher risk of miscarriages, maternal mortality and giving birth to still born or underweight babies. Iodine deficiency disorders can lead to growth retardation. Use of iodized salt is only among 50% of the households in India. **Hence tackling the problems related to malnutrition and anaemia needs to be addressed in the state in order to improve the health of adolescents.**

Adolescents are prone to drug abuse, trafficking and sex work, premarital sexual relations thus leading to increased incidence of HIV and other sexually transmitted diseases. While knowledge for contraception is being promoted, the availability and use of contraceptives is not published. Even among married women in the age group of -15-19 years there is unmet need for contraception. 19% of the TFR is contributed by this age group of mothers. Nearly 27% of them have reported unmet need for contraception. (NHFS 2)

Reasons for investing in adolescent health and development:

- To develop their capacity to cope up with the situation and deal with it positively.
- To increase relationship building capacity for happy and health married life.
- To reduce morbidity and mortality among adolescents. A healthy adolescent grows into a healthy adult.
- To inculcate healthy habits
- As human right adolescents have a right to achieve highest level of health.

Benefits of investing in adolescent health

- Health benefits for individual adolescent in terms of his/her future and in terms of inter-generational effects.
- Improved productivity, return on investment averts future health cost.
- As human right adolescents have right to attainable highest level of health.

3.4.2 Goal:

- ❖ Reduce IMR MMR TFR and HIV infections among this age group.
- ❖ Build a healthier nation in the years to come

3.4.3 Objectives of ARSH:

- ❖ Improved reproductive health status of adolescent girls and boys.
- ❖ Increase health seeking behaviour among the adolescents.
- ❖ Provide adolescent friendly ARSH services at SCs, PHCs and CHCs. Friendly means the services should be accessible, acceptable, appropriate, comprehensive, and effective and equity services for adolescents.
- ❖ Strong focus on improving the use of RCH services by poorest and under served population.

3.4.4.Strategies:

- ❖ Tackling key issues which keep away adolescents from availing benefits of health services
- ❖ Involving services of NGOs (including MNGOs and FNGOs) to increase health seeking behaviors among the adolescents.
- ❖ To make provision for demand generation activities and provision for health services at all facilities.
- ❖ Increase health awareness among the girls married and unmarried through consorted efforts from departments like women and child, education, PRIs, youth services, water supply and sanitation (to increase number of toilet users).
- ❖ Registration of all under 19 pregnancies during the first trimester.
- ❖ Involve private health providers in organizing 'Teen Clinics' on fixed days to provide health care and counseling services to adolescents.
- ❖ Poor knowledge and awareness is the root cause of reproductive and sexual problems among adolescents hence increase the knowledge on RCH and bring about behavioral changes among adolescents.
- ❖ Use of exiting VCTCs for counseling adolescents on matters related to RCH.
- ❖ At the level of health facilities providing adequate privacy, confidentiality while giving services to adolescents.
- ❖ Training of staff to provide adolescent friendly services, esp. MOs, ANMs in counseling services.

- ❖ Promotion of EC pills to prevent
- ❖ Linkages with WCD, Education and Panchayat Raj institutions.

3.4.5 Coverage:

During the year 08-09 ARSH programme with service delivery services shall be continued to be implemented in 4 districts viz. Tumkur, Chamarajnagar, Bagalkot , Koppal and introduced in 8 new selected districts with the following criteria:

- o Where more than 60% of the girls are married below 18 years
- o Incidences of teenage pregnancies are more.
- o Where literacy level of girls is less
- o Indicators show high rate of IMR, MMR and TFR.

The newly districts selected are:

1. Kolar
2. Chitradurga
3. Kodagu
4. Hassan
5. Bagalkot
6. Gadag
7. Bidar
8. Bellary

ARSH programme will be implemented in 747 PHCs and CHCs.

3.4.6. Priorities, Constraints and Actions to overcome constraints in implementing the ARSH programme in the State:

Sl. No.	Priorities	Constraints	Action to overcome constraints
1	Functional facilities – Establishing fully functional SCs, PHCs, CHCs and district hospitals to provide ASRH services	❖ Absence or dilapidated physical infrastructure ❖ Non availability of doctors/ paramedics. ❖ Drugs / vaccine shortages ❖ Dysfunctional equipments ❖ Untimely procurements ❖ Chocked fund flows ❖ Lack of accountability framework ❖ No road map to achieve the desirable results ❖ No mandatory services and lack of supervision ❖ Non availability of trained personnel for counseling services	❖ Infrastructure development ❖ Procurement of drugs and equipments ❖ Appointment of contractual staff and capacity building of the staff ❖ Streamlined fund flows ❖ Improved MIS ❖ Local level flexibility Community /PRIs/ARS for accountability and M&E Develop road maps to reach desirable goals in 5 years.

Sl. No.	Priorities	Constraints	Action to overcome constraints
2	Reducing IMR/MMR and TFR	❖ Lack of 24x7 facilities for safe deliveries and emoc services ❖ Non availability of specialists to handle high risk cases ❖ Lack of equity in family welfare services ❖ Lack of referral transport system ❖ Lack of coordination at the grass root level, each department work parallel.	❖ Make health institutions 24x7 functional. ❖ Hiring services of specialists wherever there is vacancy. ❖ Thrust on Skilled birth attendants ❖ Active village and sanitation committees. ❖ Synergy of grass root level functionaries of allied departments.
3	Action on preventive and promotive health	❖ Poor emphasis on locally appropriate communication efforts ❖ No action on healthy life style strategies ❖ Weak school health programmes ❖ Compartmentalised IEC of every scheme ❖ Absence of counseling / early detection at facilities in rural areas.	❖ IEC as per local needs ❖ Improved school health programme ❖ IEC training and capacity building ❖ Integrated IEC programmes for all schemes ❖ Trained personnel to work as counselors.
4	Convergence of programmes	❖ Lack of intersectoral coordination between health water supply and sanitation	❖ Convergence of programmes ❖ Involvement of PRIs ❖ Effective functioning of VH&SCs ❖ Effective functioning of ARS
5	Priority to handle RCH needs of adolescents at every health facilities	❖ Lack of privacy and confidentiality at health institutions to handle ARSH. ❖ Less focus on health seeking behaviours among adolescents. ❖ No statistical data on performance of private health providers in the area of adolescent health. ❖ No special interventions to reach vulnerable communities like SC/ST, street children, out of school children, in this age group.	❖ Make provision for privacy and confidentiality to handle ARSH care ❖ Special programmes to cover vulnerable population under ARSH ❖ Involve private health providers in ARSH and seek reports on teenage pregnancies, MTP cases. ❖ Special IEC for special groups

Sl. No.	Priorities	Constraints	Action to overcome constraints
6	Burden of disease among the poor	❖ Large out of pocket expenditure even while attending free public health facilities – food transport, escort, livelihood loss etc. ❖ No felt need of health care among adolescents.	❖ More efficient demand side financing to reduce disease burden of the poor. ❖ Increase awareness to strengthen health seeking behaviour among adolescents

3.4.7 Activities:

The activities can be broadly classified into:

a. Service delivery package:
b. Organising effective services
c. Conducive environment at health facilities
d. Capacity building of providers
e. Environment building
f. Communication with adolescents
g. Monitoring and supervision
h. Reporting

Make health facilities to function 24x7 by correction of infrastructures and filling up of essential staff positions to handle ARSH programme

2. Recruit and train counselors at PHCs and CHCs.
3. Put up a sign board so that the place where teen clinic is run by the health facilities.
4. Provision of equipments, supplies and contraceptives and vaccines on time
5. Develop a referral plan. Identify CHCs/DH as appropriate.
6. Map an essential package of services to be provided at each health facility.
7. Observation of village health days in an effective way so that out of school adolescents are motivated to avail services provided.
8. Guidelines on essential package of preventive, promotive, curative referral services

3.4.8. Training: (Cost for training is covered under TRAINING chapter under RCH-II)

a. State Institute for Health & Family Welfare Services and District training centers will be engaged in training of personnel to handle adolescent problems.
b. District specific training for ANMs,/LHVs/ contractual Counselors and MOs.
c. Develop training modules for different levels of training.
d. Organise master trainers and conduct TOTs for master trainers.
e. Orient district DHEOs , RCH officers and DPMs in ARSH programme implementation and to be trained in monitoring, supervision and consolidation of report.
f. Develop competency building plan
g. Translation of training modules developed by GOI.
h. Hiring of services of experts to train the staff.

3.4.9. BCC: (Cost in detailed under 3.4.11.)

i. Develop district specific strategies.

j. Production of materials required disseminating information related to themes specific to adolescents.

Level of care	Service provider	Target group	Flow of service delivery activities	Services
Sub-center	ANM	Unmarried (Males and Females) Married (Males and Females)	During routine sub center clinics	1. Enrolment of newly married couples 2. Provision of spacing methods 3. Routine ANC care and institutional deliveries 4. Referral for early and safe abortion 5. RTI/STI and HIV/AIDS preventive education 6. Nutrition counseling including anaemia prevention and personal hygiene. 7. Immunisation for pregnant adolescent mothers
PHC/CHC and DH	LHV and Counselor Medical officer	Married and unmarried males and females	Once a week teen clinic will be organized at PHC,CHC and DH for 2 hours	1. Contraceptive, and condom programming 2. Management of menstrual disorders and guidance on menstrual hygiene 3. RTI/STI and HIV/AIDS preventive education and management 4. Counseling and services for MTP 5. Nutritional counseling 6. Counseling on sexual problems 7. Immunisation for pregnant adolescent mothers

3.4.10. Expected Out comes:

1. Increased knowledge, awareness among adolescent population on matters related to personal hygiene, reproductive health, family planning, importance of safe drinking water, nutrition, RTI/STI/HIV and AIDS.
2. Improved health seeking behaviour among adolescents.

3. Better health care practices
4. Better health awareness and health seeking behaviours among vulnerable adolescent population.
5. Better services for the adolescents in the health facilities.

3.4.11. Budget for ARSH

Sl. No.	Activity	Cost of each activity	Total cost	Responsibility and time line
1	Production of IEC materials on ARSH: 1. Printing reporting formats = 2. Folders = 3. Counseling sheets = 4. Teen clinic boards = 5. Cost of telecast of documentaries = 6. Cost of broadcast Radio drama = 7. Wall paintings in the school premises = 8. POL for video vans =	Total cost for: 1. 5,00,000 2. 2,00,000 3. 1,00,000 4. 20,000 5. 10,00,000 6. 10,00,000 7. 2,00,000 8. 20,000 per annum per district	Rs.28.48,000.00	State level District level
2	Honararium for contractual staff one health educationist cum counselor at district level	Rs. 8000 x 12 districts x 12 =	Rs.11,52,000.00	One consultant for ARSH progm. To be appointed in each district
		Total	**Rs.40,00,000**	

Cost: Rs. 40 lakhs
GOI approved for Rs.40.00 lakhs

3.5. Urban Health

With increasing urbanization, growth of slums and low income population in the cities, the provision of assured and credible primary health services of acceptable quality has emerged as a priority thrust area for both the central and state Governments. The need has arisen to create a well-organized health service delivery structure in urban areas especially for poor people living in slums.

The emerging importance of the problem can be gauged from the fact that the total population of Karnataka state is 5,28,50,562 and the urban population is 1,79,61,529 .

3.5.1. Goal and objective of the program:

To improve the health status of the urban poor community by the provision of quality integrated Primary Health Care services.

3.5.2. Objective: The main objective of the program is to provide an integrated and sustainable system for primary health care services delivery in the urban areas of the country, with the focus on the urban poor living in slums and other health vulnerable health groups. To attain this, the specific objectives will be:
Establishing new facilities in 34 identified urban slums areas, which are not covered by urban health centers.

Establish referrals with tertiary care centers, i.e. District hospitals, Medical colleges etc for institutional deliveries, emergency obstetric care and terminal method of family planning.

Appoint link workers who will act as link between community and health facility.

Program description:

3.5.3. Coverage: The program would be implemented in a phased manner in 34 selected towns of Karnataka states. The proposed urban health program will focus on cities having a population between one to ten lakh/ It is proposed to cover these cities in the phased manner as per the following:

Phase	I	II	III	IV	V	Total
Year	2005-06	2006-07	2007-08	2008-09	2009-10	
No. of centers	4	6	8	8	8	34

3.5.4. Strategies:

State level steering committee for urban health activities has been constituted.

Mapping of 34 urban slums has already been completed; basic demographic and health indicators have been collected. For the current year it has been proposed to implement the urban heath project in 8 centres.

Each of proposed urban health centers will cover a population of 50,000.

Lady medical officers will be appointed on contractual basis for all the selected urban centers. She will be responsible for providing all OP services and also she will conduct at least 4 outreach visits in her geographic area.

Identification of tertiary referral centers will be done by Lady medical officer of UHC in coordination with the District health officer and will establish formal linkages for service delivery.

Para-Medical Staff i.e, JHAF, SHAF etc and other staff will be appointed on contractual basis. Each JHAF/ANM will cover 15,000 populations for providing outreach services. She has to prepare a micro-plan showcasing the area and days on which outreach services will be provided.

To develop and maintain a link between the health facility and the community, the program envisages the engagement of female link workers for every 5000 population who are in the age group of 23-35 and are able to spare three to four hours a day, and are acceptable to the community and preferably to be engaged through local NGOs.

Training: The training programs will be conducted for newly appointed staff of urban health canters.

3.5.5 Budget requirements:

Budget requirement for appointing Staff for one Urban Center and their remuneration is as follows:

Name of the Post	Number of Posts	Remuneration (Rs. / Month)	Cost per year Rs.
Medical Officer (LMO)	1	17000/-	204000.00
LHV / PHN	1	6500/-	78000.00
ANM	3	5500/-	198000.00
Lab technician	1	5000/-	60000.00
Clerk	1	5000/-	60000.00
Link Worker	10	700/-	84000.00
Security Guard	1	4000/-	48000.00
		Total	**732000.00**

Annual Maintenance of equipments, Furniture etc. / Health Centre (Recurring).	Rs. 10000.00
Electrical, Water, Building charges etc., (Recurring)	Rs. 50000.00
Building maintenance (repair & painting) (Recurring)	Rs. 50000.00
Drugs (Recurring)	Rs. 30000.00
IEC Materials (Recurring)	Rs. 10000.00
Hiring of Vehicles (Recurring)	Rs. 12000.00
Rent for the building	Rs. 100000.00
Total (1 to 9)	**Rs. 994000.00**

Equipments* Rs. 10,00,000.00
Furniture* Rs. 01,00,000.00
(* Non Recurring cost proposed to be met out by States)

1.	Recurring cost met by GOI	994000.00
2.	Non recurring cost met out by State Govt.	1100000.00

During 2008-09 it is proposed to take up 08 Urban centers for implementation of Urban health scheme.

Centers started during 2006-07	10
Centers started during 2007-08	08
Centers proposed during 08-09	08
Total centers	**26**

Keeping in view that most of the Urban health centers, will redeploy the existing staff and most of the centers may start in Government buildings where rent is not required the budget is prepared accordingly.

3.5.6. Budget:

Sl. No.	Particulars	Cost per center	No. of Centers.	Total cost in Rs.
1	Salary for staff (excluding link Workers)	648000	12	7776000.00
2	Salary for link workers	84000	26	2184000.00
3	Annual Maintenance of equipments, Furniture etc. \	10000	26	260000.00
4	Electrical, Water, Building charges etc., (Recurring)	50000	26	1300000.00
5	Building maintenance (repair & painting) (Recurring)	50000	16	800000.00
6	Drugs (Recurring)	30000	26	780000.00
7	IEC Materials (Recurring)	10000	26	260000.00
8	Hiring of Vehicles (Recurring)	12000	26	312000.00
9	Rent for the building	100000	10	1000000.00
	Total			**1,46,72,000.00**

Cost: Rs.146.70 lakhs

GOI approved for Rs. 147.00 lakhs

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3.6 TRIBAL AND VULNERABLE POPULATION

(Cost of each activity is detailed in 3.6.7)

3.6.1 Introduction

Karnataka State has a strong commitment to improve the health status of its population, particularly the poor and vulnerable groups including women, children and those belonging to tribal, nomadic and other vulnerable (T&V) groups. Karnataka has 34,63,986 Scheduled Tribes and 85,63,930 of Scheduled Castes population. This represents 6.55% and 16.20 % of the total population of Karnataka respectively (as per 2001 census). Of this totalof SC/ST population 20% are tribals and the other vulnerable groups. Knowing very well ST & SCs particularly the triblas have a high disease burden particularly in mothers and children, the RCH II program needs to address this group specifically. This is compounded with illiteracy, poverty, malnutrition, poor sanitation and inadequate access to safe drinking water, utilization of health services by Tribal &Vulnerable is low due to the difficult geographical conditions and the social constraints in which they live. Their settlements tend to be small and isolated and difficult to reach with facilities and services. Even when they live in larger villages they may be separated in hamlets and pockets.

The health related goals for the T&V groups are:

a. Reduce Child Mortality
b. Improve Maternal Health
c. Combat HIV/AIDS, Malaria, TB and other specific diseases to tribals like sickle cell anemia

3.6.2 Situation Analysis

1. Even though Karnataka remains a high performer in health status when compared to many other states in India with better health indicators, there is scope for improvement. Disaggregated data indicate substantial disparities in various indicators across 27 districts in the state with much worse indicators among the tribal and vulnerable groups.
2. The maternal mortality as well as infant mortality is stated to be specifically high as reported in the State Government (CNA Form 9) and as reported for various morbidity conditions in mothers and children in DLHS- RHS. NFHS 3 data which is the most recent RCH data also confirms the same.

Hence the need to address RCH issues in this vulnerable and tribal group in a focused manner.

Table showing deliveries in the 3 districts with high tribal population:

	Deliveries 2006-07
Districts	total
Kodagu	7217
Chamraj nagar	41097
Mysore	13010
Total	**61324**

3.6.3. Objectives:

The specific objectives of the program to implement tribal and vulnerable population health are to:

- To provide RCH services based on the unmet RCH needs in tribal and vulnerable communities.
- Making the RCH services integrated, appropriate and quality based.
- Ensuring equitable access to all the tribals and nomads or other vulnerable groups irrespective of their geographic or social constraints.
- Educate the population to appreciate the need for improved RCH care and thus create demand for these services.
- Improve service coverage and acceptability and ensure uniformity in supply of services to all the groups.
- Promote community participation and inter-sectoral coordination
- Promote and encourage safe health practices and use alternate systems of medicine if found suitable for these groups.

3.6.4. Strategies to be adopted:

- Improving the accessibility
- Infrastructure development
- Incentives to health functionaries- Human resources
- Training
- JSY
- IEC
- Equipment , drugs and supplies

3.6.5. Community Participation:

Karnataka has been home to many innovations. One of the objectives of the project is to reduce MMR. And this rate is unacceptably high amongst the women belonging to poorer communities. In order to create awareness on safe delivery practices, Mahila Mandals and Stree Shakthi Groups can organize 'Samooha Seemantham' or Community Celebration of pregnancy as in the neighboring state of Andhra Pradesh which has proved to be a good strategy for getting the community actively involved in spreading awareness about safe delivery, post-natal care etc. . On this occasion, pregnant women are honored with a Kum-Kum Tika (Vermillion on their forehead) and are given some incentive like blouse pieces and bangles.

3.6.6. Activities:

3.6.6.1 Tribal area allowance

To improve the availability of the services and to run 24x7 PHCs it is envisaged to encourage the staff to stay in the tribal areas will help in This is due to lack of accommodation for the staff and poor educational facilities for their children. Also, a special allowance may be paid to the staff posted in tribal areas Tribal area allowance/ additional

incentives to health functionaries. Each doctor/ Nurse/ ANM posted in a tribal PHC will get extra allowance as an additional compensation to 2000/ 1000/ 750 pm.

In the 3 districts namely- Kodagu, Mysore and Chamrajnagar there are

	PHC	
Districts	With building	Without building
Kodagu	26	3
Chamraj nagar	54	42
Mysore	50	2
Total	130	47

It is proposed to give an additional allowance of Rs. 2000 to doctors, Rs.1000 to staff nurses and Rs.500 to ANMs working in tribal areas. In the 1st phase we will give this allowance to all the staff said above at all 26 PHCs in Kodugu, and half the PHCs in Chamrajnagar (27) and Mysore (25) districts (total 78 PHCs). Staff staying in the head quarter only is eligible for this allowance.

The budget for doctors	=	78x2000x 12	= 18,72,000
The budget for staff nurses	=	78x1000x 12	= 9,36,000
The budget for ANM	=	78x750x 12	= 7,02,000
		Total	**= 35,10,000**

3.6.6.2. The salary component of 25 tribal ANMs working in PHCs which are out sourced under PPP is to be met out of RCH funds (Rs 10 lakhs). These ANMs are working in tribal areas and are continued from RCH-I

3.6.6.3. Chiranjeevi scheme (Outsourcing of deliveries to private hospitals):

Introduction:

- Karnataka has a shortage of specialists in the rural areas especially –Gynecologists and obstetricians as well as anesthetists and pediatricians.
- Many of the sanctioned posts are lying vacant
- Lack of specialists has constrained the institutional capacity to deliver high level of skilled RCH services such as EmOC and institutional neo natal care in the government set up.
- The Sate has a large number of its own health facilities but the accessibility of the services is not satisfactory
- But there are many specialists working in the private sector
- Public Private Partnership is seen as a panacea for all problems
- Innovative scheme of contracting private specialists so as to provide maternity services in private hospitals (Chiranjivi scheme of Gujarat)
- This will expand the service and offer cafeteria choice for the expectant mother

Objective:

- To increase the skilled birth attendance
- To increase the institutional delivery rate
- To buffer against the high cost of emergency obstetric care.

Strategy:

- Scheme for BPL women and women who get authorization from the local authorities to enable them to avail the scheme.
- Private providers are empanelled in the identified districts to provide the delivery care package as depicted in the table below.
- The private providers to be screened by District health society so as to be sure of the facilities being provided for emergency obstetric care in their private facilities
- Facility survey to be conducted.
- Private providers are reimbursed for every 100 deliveries on a capitation basis
- Empanelled private providers are given Rs 20,000 as advance and subsequently reimbursed Rs2, 39,500 for every 100 deliveries conducted in their own private facility.
- Capitation package developed after the Gujarat model but provision has been made for escalation
- Sensitization workshops to be conducted per district.
- Extensive IEC by the government for the families as well as for the providers
- Dignity of the specialists to be respected through mutual interaction and trust.
- Simple reporting formats to be used for the reporting at the Taluka level.
- Strong government ownership and support for implementing

Package

Service	Contracting out OBG in their private facilities		
	No of cases	Estimated cost	Total Rs
Deliveries			
Normal	85	1000	85,000
Complicated			
• Eclampsia	0	1000	
• Forceps/Breech	3	1000	3000
• Episiotomy	0	800	
• Septicemia	2	4000	8000
• Blood transfusion	3	1500	4500
LSCS	7	6000	60000
Pre delivery cost	100	100	10000
Other costs			
• Investigation	100	50	5000
• sonography	30	300	9000
• NICU	10	1000	10000
• Food	100	100	10000
• Dai	100	50	5000
• Transport	100	300	30000
Total for 100 deliveries			2,39,500

Hence for a package of 100 deliveries a sum of Rs 2lakh 39 thousand &500 is proposed.

The above scheme is to be taken up as a pilot in 1districts and to be scaled up in the other districts subsequently.

The number of BPL women in the backward districts who deliver at home is around 70%. is to be taken as a pilot in the 1 districts and to be extended through out the state if successful

Enrolment of the private sector providers who have the necessary clinical infrastructure to be done on a priority by the District Health Society

The funds will be operated through the District health society.

Criteria for empanelment:

- The private nursing facility should have a minimum of 10 beds
- A functioning OT and labour room
- Gynecolosist
- Anesthetist on call
- Paediatrician on call
- Link with the blood bank.

Monitoring:

The scheme to be monitored by simple formats as ell as random field visits by the State and District authorities

Cost : Rs.226 lakhs

3.6.6.4. Cell phone: Access to mobile communication services within 1 Km. in each of the tribal/ vulnerable community One cell phone is to be provided to the ANM with connectivity to BSNL. It will be ensured that each woman has access to the cell phone within a radius of 1 kilometer. (provided in the previous years budget)

However recurring cost will be Rs 100 pm

SN	Activity	
4	Recurring cost pm	Rs 100
5	Total recurring cost	Rs 9.3 lakhs (Rs 100x12x780)
	Grand total	Rs 9.3 lakhs

3.6.6.5. Budget:

Sl. No.	**Component**	**Rs. in lakhs**
1	Salary component of tribal ANMs 25 ANMs	**10.00**
2	Recurring cost of mobile phones @ Rs 100 pm x12 months	**9.30**
3	Chiranjivi yojana 9 disricts	**226.00**

Sl. No.	Component	Rs. in lakhs
4	Tribal area allowance Doctor @ Rs 2000 pm x 12 Staff nurse@ Rs 1000 pm x 12 ANM @ Rs 750 pm x 12	**35.10**
	Total	**280.40**

Cost: Rs. 280.40 lakhs

GOI approved for Rs.280.00 lakhs

3.7 PPP MNGO Scheme

MNGO scheme will be implemented in all 29 districts. FNGOs to be selected in 13 districts. Ten Service NGOs will be selected in selected districts. Budget to be released to the newly selected MNGOs and FNGOs. Salary for State NGO coordinator is also budgeted . The programme cost would be Rs.160 lakhs. The unspent balance amount for the year 2007-08 will be utilized for additional budget.

Cost Rs. 160.00 lakhs

3.8. Behaviour Communication Change

Activities planned;

3.8.1. BCC Bureau at the state and district level:

- ❖ Strengthening of the bureau by providing manpower to monitor, document and help in organizing programmes in the districts.
- ❖ Provide AV operators to organize video shows in the districts
- ❖ Provide AV equipments to 15 districts where the projectors are not working
- ❖ Equip IEC section with computers.
- ❖ At the state level one person will be appointed on contract basis to look into the documentation of the IEC activities held at both State and district level
- ❖ One computer assistant at the State BBC bureau on contract

3.8.2 IEC activities at district and State level:

a. Print media: Activities planned include:

i. News letters at State and district level in the form of broachers, leaflets or profile books

ii. News paper advertisements

iii. Guideline books

iv. Broachers on maternal health and child health

v. Posters, charts, wall calendar and pocket calendars

b. Electronic media: Telecast of TV spots, panel discussions, phone in programmes etc., Production of TV Spots. Telecast spots through CCTV at railway station and bus stand. Broadcast of radio jingles, drama, and phone in programmes.

c. Traditional media: Training folk media artists in NRHM initiatives and organizing folk media programmes in the rural areas during multi media campaigns.

d. Exhibition media: Organising mobile exhibitions, tableau putting up hoardings,

e. Observation of special days

f. Focused group discussions for mothers, adolescents, PRI members, SHG members at PHC level.

g. Capacity building programmes for members of Village health and Sanitation committees at PHC level

h. Organising Health Mela and multi media programmes at taluka level

i. Divisional level intra communication activities: Orientation meetings and review meetings for the health educators.

3.8.3. BUDGET (Amount in Lakhs)

District Level BCC Bureau				
Sl. No.	**Particulars**		**Cost per unit**	**Total cost**
1	Manpower		29x8000x12	27.84
		Operators	29x3000x10	8.7
2	Vehicle		29x500x10x10	14.5

3	Equipment	A.V.Projector	15x60,000	9
		Computer	25x50,000	12.5
		Furniture	29x20,000	5.8
			Sub Total	**78.34**

State Level BCC Bureau

Sl. No.	Particulars		Cost per unit	Total cost
1	Manpower	Manager	10,000x12	1.2
		Computer assistant	5,000x12	0.6
2	Office set up			40.98
			Sub Total	**42.78**

BCC Activities at District Level

Sl. No.	Particulars	Quantity	Cost per unit	Total cost
1	Newsletter	5,000 Copies	Re. 1.00x10monthsx29	14.5
	District profile books			
	Leaf lets			
	Brouchers			
	Miscallaneous		200x29x10	0.58
4	Newspaper Ads.		25,000x29	7.25
5	C.D Player	29	10,000x29	2.9
6	World Events Days	4	10,000x29x4	11.6
	Campaigns	2	10,000x2x29	5.8
	PHC Level			
1	Mothers meeting	1679	500	28.19
2	Orientation to PRI members Taluka level	176	6,000	10.56
			Sub Total	**81.38**

BCC Activities at State Level

Sl. No.	Particulars	Quantity	Cost per unit	Total cost
1	News letter	15000x2		3
	Photos & other expenditure	1000x2		0.2
2	Mobile exhibitions	4		5
	Tablau	4		5
3	Multi media campaings			
	Vehicle to carry artists	4		5
	Artisits team		10000x4x6 months	2.4
4	Advertisements	State news papers, periodicals & others		25
5	Hoardings bus panels			25
6	Booklets			15
7	Broachers on maternal health			2.2
8	Broachers on child health			2.2
9	Posters			2

10	Charts			1
11	Guideline books			2.6
12	Broadcast through AIR			25
	jingles, dramas, phone-in- programmes			
13	Telecast through doordarshan & pvt. Channels			25
	panel discussion, preparation of VCDs, spots, documentaries,			
	CCTV at bus stand and Railway station			
			Sub total	**145.6**
14	Observation of special days			10.00
15	Divisional level intracommunication			0.8
16	Workshops and review meetings			0.6
17	Manpower for printing press on contract			2.4
18	Misc. (AV equipment repairs etc)			10
			Sub Total	**23.8**
			Grand total	**371.90**

GOI approved'for Rs. 325.00 lakhs

IEC Under NRHM flexi pool Rs. 100 lakhs approved by NPCC

Sl. No.	Particulars	Quantity	Cost per unit (in lakhs	Total cost
1.	Exhibition on wheels – a vedeon van with accessories & Operational cost	1	15.00 for van and 2 lakhs accessories and 20,000 pm operational cost towards drived, POL etc (6 months)	18.20
2.	Printing of Books on NRHM			15.00
3.	NRHM achievement annual book			5.00
4.	Folders 5 varieties			5.00
5.	News paper add			10.00
6.	Divisional level workshop for fold media artists	4	0.5	1.00
7.	Fold media programmes		0.25	10.00
8.	Eshibition boards for state HQ	25	0.6	2.00
9.	Stickers for pasting on vedeon vans			1.00
10.	Fax machines and computer and its accessories for state IEC bureau	1 set		1.2
11.	Production of TV spots	8	0.25	2.00
12.	TV programmes – telecast of TV spots on NRHM activities			15.00
13.	Broadcast of Radio jingles/drama			14.00
14.	Misc			0.60
			Total	100.00

3.9 TRAINING

(Cost of each training activity is detailed in 3.9.8)

3.9.1 Background:

The Department of Health and Family Welfare has adequate human resource. It is necessary to strengthen their skills to deliver health care services effectively to the community. In this context, the health personnel needs to be sensitized, trained and re-trained in the newer technology.

3.9.2 Objectives of the training:

- Capacity building of the Medical and Para Medical staff in the department of health and family welfare is under taken for effective implementation of the programme in the community.
- Capacity building of the Medical and Para Medical staff in development of skills in delivering the health services.
- Development of leadership quality of the medical officers, other supervisors at block, district and state level.
- Effective management of the finances at different levels of the activities.
- State Institute of Health and Family Welfare, Bangalore works as the nodal center for training in RCH. Along with other centres at district and division levels.
- Medical colleges works with the department of health and Family Welfare in development of the skills of the health personals, and for monitoring and evaluation of the different activities at community level.

3.9.3 Planning is done under following heads:

1. Infrastructure development
2. Equipment required for the training
3. Training manual development
4. Special equipment required for the training
5. Trainings planned under different strategy in RCH

3.9.4. Infrastructure Development:

Repairs and renovations needed for the 19 ANMTC's and 2 LHVTC's. And teaching and training equipment for the same institutions like OHP, Computers, LCD projector and other required accessories.

3.9.5. Training manual and special training equipment:

Training manual available from GOI for different trainings under RCH, the same need to be translated to the local language and to be printed. Special training equipment like Baby resuscitation mannequin, ZOE model for IUCD insertion for training in IUD as alternate method for the training.

3.9.6. Training on the following topics is contemplated:

3.9.6.1. Maternal Health; Under maternal health trainings are mainly planned to develop the skills of Medical and Para medical personals in Management of ANC, conducting delivery, active management of the III stage of the labour, early identification and management of the complication during ANC, Natal and PNC. Management and referral of RTI/STI .

3.9.6.2. Child Health: Under Child Health programmed trainings are planned to develop the skills in at birth care, management of the new born at the facility and at home, integrated management of the neonatal and child hood illness. Immunization programme.

3.9.6.3. Family Planning Programme: Under family planning programme trainings are planned to develop skills in conducting tubectomy, IUD insertions etc,.

3.9.6.4. Adolescent Reproductive Sexual Health: Capacity building of the all category of staff in ARSH is under taken through involvement of Karnataka AIDS control Programme, NGO's working in the field of Adolescent health and Medical colleges

3.9.6.5. ASHA training: ASHA training is done through identified NGO's for the 9 districts and programme will be extended to the rest of the districts in the similar way.

3.9.6.6. Other National Health programmes; Capacity building of the health personnel in other heath programmes also been done as per the national guidelines.

3.9.7 Infrastructure available under Training:

Table Showing the Training Institutions in the state with staff and Infrastructure available

Sl No	Name of the Institution	No.	Faculty	Infrastructure	Remarks
1	SIHFW	1	Director, Joint Director, 10 Deputy Directors and supporting staff	1 Administrative Block and 1 Training Block with 1 Conference Hall, 5 class rooms with LCD, Over Head Projector, Slide Projector, well equipped library and Hostel facility for 35 members.	
2	HFWTC	4	Principal, MLCD, Epidemiologist, Communication faculties and supporting staff	3 Class rooms, with all teaching aids, library and field demonstration station, Bus and jeep/ tracks. In house facility for 40 members.	
3	DTC	19	Principal, HEO and DNO and supporting staff	class room, in house facility for 30 persons with library and all teaching aids.	

Sl No	Name of the Institution	No.	Faculty	Infrastructure	Remarks
4	ANMTC	19	Principal, 6 tutors with supporting staff	1 class room, in house facility 40 trainees, library with adequate teaching aids	
5	LHVTC	4			
6	District Hospitals	27	TOT trained OBG, Pediatrics, Skin specialists etc		For Hands on practice in skill Training
7	CHC, TH and GH	252	TOT trained OBG, Pediatrics, Skin specialists etc		For Hands on practice in skill Training & Field visits.
8	Medical college hospitals	4+20 Private Colleges	TOT trained OBG, Pediatrics, Skin specialists etc		For Hands on Training

3.9.8 Budget:

Training budget under RCH for the year 2008-09

Sl. No.	Particulars	Rs. In lakhs
1	**Strengthening of Training Institutions (SIHFW, HFWTC,DTC,LHVTC and ANMTCs, etc.)**	
2	Carry out repairs/ renovations of the training institutions: 11 institutions	110.00
3	Provide equipment and training aids to the training institutions 21 institutions	21.00
5	Web based data development under training	50.00
6	**Development of training packages**	
7	Development/ translation and duplication of training materials-19,000	19.00
8	Specialised training equipment (for skills trainings) provided(Baby Resuscitation Mannequin-59)	14.75
10	**Maternal Health Training**	
11	**Skilled Attendance at Birth / SBA**	
12	Setting up of SBA Training Centres-42	0.93
13	TOT for SBA	
14	Training of Medical Officers in SBA-500	50.00
15	Training of Staff Nurses in SBA-750 from 750 PHC(2/PHC)	138.80
16	Training of ANMs / LHVs in SBA-750 from 750 PHC(2/PHC)	138.80
17	**EmOC Training**	
18	Setting up of EmOC Training Centres-10	FOGSI

Sl. No.	Particulars	Rs. In lakhs
19	TOT for EmOC-5	FOGSI
20	Training of Medical Officers in EmOC-10	FOGSI
21	**Life saving Anaesthesia skills training**	
22	Setting up of Life saving Anaesthesia skills Training Centres-5	4.00
24	Training of 54 Medical Officers in life saving Anaesthesia skills	17.20
25	**MTP Training**	
26	TOT on MTP using MVA(16 Mos)	0.80
27	Training of Medical Officers in MTP using MVA(100 Mos)	8.75
28	Training of MOs in MTP using other methods (pl. specify)-conventional using MR syringe and dilatation and curettage	7.48
29	**RTI / STI Training**	
31	Training of laboratory technicians in RTI/STI (1000 Lab Techs)	9.20
32	Training of Medical Officers in RTI/STI (1000 MOs)	32.00
33	Training of 2000 Staff Nurses in RTI/STI	18.40
34	Training of 4000 ANMs / LHVs in RTI/STI	36.80
36	Trg of MO / Lab Tech/Staff nurses in blood stroage unit-in 269 FRU	56.00
40	**IMEP Training**	0.00
41	TOT on IMEP- (20 members from dists)	0.80
42	IMEP training for state and district programme managers	0.00
43	IMEP training for medical officers-3358 Mos) from 1678 PHC	53.76
44	**Child Health Training**	0.00
45	**IMNCI Training (pre-service and in-service)**	0.00
46	TOT on IMNCI (pre-service and in-service)(for 5 districts (Belgum, Bagalkot,Dharwad, Uttar kannada & Heveri)	6.25
47	IMNCI Training for Medical Officers-from 10 districts	50.00
48	IMNCI Training for staff nurses-1000 from 10 districts	50.00
49	IMNCI Training for ANMs / LHVs-1800 from 12 Districts	75.00
50	IMNCI Training for Anganwadi Workers- 3600 from 12 Districts	100.00
51	**Facility Based Newborn Care / FBNC Following GOI guidelines**	0.00
52	TOT on FBNC-323	1.20
53	Training on FBNC for Medical Officers	2.40
54	Training on FBNC for SNs	2.40
55	**Home Based Newborn Care / HBNC**	0.00
56	TOT on HBNC	2.40

Sl. No.	Particulars	Rs. In lakhs
57	Training on HBNC for ASHA	36.00
58	**Care of sick children and severe malnutrition Following GOI guidelines**	0.00
59	TOT on Care of sick children and severe malnutrition	1.20
60	Training on Care of sick children and severe malnutrition for Medical Officers	3.60
61	Other child health training(Routine Immunization ANMs and health workers)	142.20
62	**Family Planning Training**	0.00
63	**Laparoscopic Sterilisation Training**	.0.00
64	TOT on laparoscopic sterilization and minilap / work shop to dissemination of standards of male and female sterilization manual and quality assurance manual (80 MOs)	0.34
65	Laparoscopic sterilisation training for medical officers-in team comprising of Gynecologist/ surgeon with staff nurses and OT attender (108)	0.68
66	**Minilap Training**	0.00
67	Minilap training for medical officers-(Team comprising of 1 MO 1 S/N & 1 OT Atttender : 570)	2.96
68	**Non-Scalpel Vasectomy (NSV) Training**	
71	**IUD Insertion**	
72	TOT for IUD insertion and contraceptive update-232 members for 29 Districts	0.80
73	Training of Medical officers in IUD insertion	50.40
74	Training of staff nurses in IUD insertion-1679	10.00
75	Training of ANMs / LHVs in IUD insertion- 600	15.00
78	**Adolescent Reproductive and Sexual Health/ARSH Training**	
79	TOT for ARSH training:40 MO in 8 Districts	0.30
80	Orientation training of state and district programme managers:40	0.10
81	ARSH training for medical officers-500	10.60
82	ARSH training for ANMs/LHVs-1000	17.20
83	ARSH training for AWWs-2000	16.00
84	**Programme Management Training**	
85	Training of SPMSU staff	0.10
86	Training of DPMSU staff	0.60
87	**Multi skill training to AYUSH Doctors (4 wks training)**	20.00
	GRAND TOTAL	1395.40

GOI approved for Rs. 850.00 lakhs

3.10 Health Management Information System

(Costing is detailed in 3.10.4)

Triangulation of Monitoring and Evaluation of all the programmes covered under NRHM is contemplated for the year 2008-09. Data collection through MIES formats, external evaluation and focus on community monitoring (to be piloted in 12 districts) is planned.

3.10.1. MIES:

3.10.1.a. Monitoring System:

Information is collected at various levels under different programmes in the revised MIES format designed and prescribed by Government of India under NRHM. Implementation and progress of the programmes are monitored based on the information collected and collated at different levels. The details of vulnerable communities like SC and ST are collected separately in the new MIES format. The system of collecting information from private sector facilities has also been streamlined.

3.10.1.b. Requirement of computer software for analysis of data

Computer software for compilation and analysis of data collected in the new MIES format to be supplied by GOI, otherwise the software has to be developed for district and State level reporting.

3.10.1.c. Quality of data

The coverage, quality and adequacy of data are being evaluated and discussed in the monthly review meeting and shortfall if any will be communicated to the concerned district authorities for needful correction measures.

3.10.1.c. Formats and flow of information under NRHM.

Form-1 : For information of Sub center covering the village under the jurisdiction and to be reported to the concerned PHC

Form-2 : For information of PHC covering all the Sub centers under the jurisdiction and to be reported to the concerned Taluk Health Office.

Form-3 : For Taluk information covering all the PHCs under the jurisdiction and to be reported to the concerned District Health Office.

Form-3A : For information of private health facility institutions in the taluk/district to be reported to the concerned Taluk/District Health Office.

Form-4 : For District information covering all the Taluks and private institutions under the jurisdiction and to be reported to the State.

3.10.1.d. Activities:

A. Printing of revised MIES formats prescribed under NRHM

Prior to the implementation of NRHM, the information of various programmes under RCH were being collected through Community Need Assessment Approach (CNAA) formats. The CNAA formats have since been revised in tune with needs of NRHM and new MIES formats have been evolved by GOI for reporting by the States. From April 2007 onwards, the data have to be collected from Sub Center level to District level in the new MIES formats and the data have to be collected and analyzed district wise at the Directorate.

These formats have to be printed and supplied to all health facilities starting from Sub Center and upwards. The expenditure to be incurred towards printing would be incorporated in the State Programme Implementation Plan.

Details of Requirement of Format & Cost of Printing

Sl. No.	NRHM Format No.	Institution	No.of Institutions	Requirement of formats per annum	Approxi. cost/format Rs	Total Cost Rs
1	1	Sub Center	8143	204000	4.00	816000.00
2	2	PHC	1879	43200	5.00	216000.00
3	3	Taluk	176	4560	5.00	22800.00
4	3A	Private/ NGO	2000	48000	2.00	96000.00
5	4	District	27	720	6.00	4320.00
					Total	**1155120.00**

The approximate cost of printing would be Rs 12.00 lakhs.

B. Orientation Training:

District level officials like RCH Officer, ASO and DNO have to be oriented to the new reporting format under NRHM. About 150 persons are to be oriented and to cover the cost of training and refreshment, about **Rs 45000/** - is required.

D. Printing of Registers:

ANC registers, EC Registers and other Registers are maintained by ANM and other field staff from Sub Centre and upwards for collection of information as NRHM requirement. These registers are to be printed and supplied. The cost of printing these registers would be about **Rs 50 lakhs..**

3.10.6. Budget :(Rs.in lakhs)

1.	Printing of forms	=	12.00
2.	Orientation training	=	0.45
3.	Printing of registers	=	50.00
4.	**Total**	=	**62.45 lakhs**

3.10.2. Evaluation Study:

There are several new interventions that have been proposed and implemented under RCH/NRHM programme. It is necessary to carry out evaluation study on the usefulness of these interventions, its impact on target group etc. It is proposed to carry out evaluation studies every year on various aspects of RCH/NRHM interventions. The amount required for the purpose will be Rs 10 lakhs per year.

Cost: Rs. 10.00 lakhs

3.10.3. Community Monitoring:

The NRHM Framework for Implementation outlines the composition and broad roles of monitoring and planning committees at various levels and stresses on developing the process of Community Monitoring.

Under NRHM. it is desired that the Civil Society is involved in full capacity in the implementation and monitoring of NRHM program. Hence it is proposed to extend Community Monitoring to 12 districts in the State during 2008-09. The budget is worked out based on the Government of India Guidelines given in the *Manual on Community Monitoring of Health Services under NRHM.*

3.10.3.a. Activities:

a. Preparation of model Community monitoring tools, training, orientation and awareness materials and documentation formats at national level
b. State Preparatory meetings and Workshops
c. State mentoring team formation, finalization of state appropriate frameworks
d. State Training of trainers – one state level workshop for Facilitators. Training of Community Monitoring teams at different levels will be conducted by NGO facilitators in the pilot phase.
e. District workshop – one in each district. Formation of District mentoring teams.
f. Block level training for four members of a Block Community Monitoring team, including at least two civil society members.
g. Community mobilization and formation of Community Monitoring committees at different levels starting from village level.
h. Orientation of members of Community Monitoring committees at all levels.
i. Block and district level community monitoring exercises would include a *public dialogue* ('Jan Samvad') or *public hearing* ('Jan Sunwai') process once or twice in the year in each PHC and Block.
j. Process documentation, state evaluations and end phase state workshops in all states

Though, initially Karnataka has not been taken up for pilot phase on Community Monitoring, as per GOI guidelines, now the pilot scheme is under way in Raichur, Gadag, Chamarajanagar Kolar Districts for the year 2007-08.

During 2008-09 community monitoring will be taken in 12 districts (3 each in the 4 revenue divisions).

The budget required for the block level activities like Orientation of members of Community Monitoring team, formation of Community Monitoring Committees, conducting Jan Samvad/Jan Sunwai in PHCs and Blocks etc. and will cost Rs 207250/block

The average amount required per district including block level activities is 16.55 lakhs and for 12 districts the budget requirement is 198.60 lakhs.

3.10.4. Budget: (Rs. In lakhs)

1.	MIES formats:	62.45
2.	Evaluation study:	10.00
3.	Community monitoring:	198.60

Total : 271.05

Cost: Rs. 271.05 lakhs

GOI approved for Rs.225.00 lakhs

3.11 PC & PNDT

(Costing for activities under 3.11.2)

The state of Karnataka is also affected by the phenomena of reduction in child sex ratio. However the situation is not as alarming as that of the situation in Punjab and Haryana. In spite of this fact the PC and PNDT Act is being implemented strictly through out the state of Karnataka. The child sex ratio in Karnataka (district wise). is given below.

Sl. No.	District	1991	2001
1	Belagaum	955	921
2	Bijapur	956	928
3	Mandya	959	934
4	Gulbarga	959	938
5	Bagalkot	NA	940
6	Bidar	962	941
7	Bangalore ®	957	942
8	Bangalore (U)	950	943
9	Dharvad	952	943
10	Davangere	NA	946
11	Chitradurga	960	946
12	Uttar Kannada	949	946
13	Ballary	957	947
14	Tumkur	970	949
15	Gadag	NA	952
16	Dakshina Kannada	956	952
17	Koppal	NA	952
18	Shimoga	961	956
19	Haveri	NA	957
20	Hassan	967	958
21	Udupi	NA	958
22	Chikkamagalur	978	959
23	Kolar	971	959
24	Mysore	966	962
25	Raichur	965	964
26	Chamarajnagar	NA	964
27	Kodagu	957	977
All India average		945	927
Karnataka average		960	946

As seen from the figures given above, only in Belgaum District the child sex ratio is lesser than the national average. The child sex ratio is lesser than the Karnataka average in 13 Districts of Karnataka. In Kodagu district of Karnataka, the child sex ratio has actually increased by 20 points.

3.11.1 Activities:

A) Establishment of PNDT cell:

In view of the above mentioned facts it has been decided that a special cell must be established in the Directorate of Health & Family Welfare Services to implement the provisions of PC & PNDT act in the 13 districts where the child sex ratio is below state average.The provisions of PC & PNDT Act and Rules are being implemented by the District Appropriate Authorities. In the meeting of the Karnataka State Supervisory Board held on 30-12 2006, it was resolved that a separate cell must be constituted in the Directorate of Health & Family Welfare Services.

B) IEC activities:

The public at large is still unaware of the provisions of PC & PNDT Act and also regarding the bane of female feticide. It is necessary to reach the public through the electronic and print media, hence adequate provisions are made in the PIP in this regard. Apart from electronic and print media, it is also proposed to conduct a state level workshop and several district level workshops. Suitable provisions are also made in the PIP for carrying out these activities.

3.11.2. Budget

1.	**Honorarium and TA of Legal Assistant**		
	a) Honorarium of legal assistant 15000x12	1,80000	180000
	b) Towards traveling allowance of legal Assistant	20,000	20,000/-
II	Provision towards establishment working of separate cell for PNDT		
III	Towards IEC activities		
	1) Electronic media:		
	c) Towards tele casting of TV spots at Rs 10,000/- per spots five days in week Rs 50000/-x46 weeks	23,00,000/-	23,00,000/-
	2) Print media		
	a) News paper advertisements (state level)	3,00,000/-	3,00,000/-
	c) Advertisements in magazines and periodicals (Kannada)	2,00,000/-	2,00,000/-
	4. Workshop at state level		
	Organising state Level workshop, as decided instate Supervisor Board Meeting held on 30.12.2006 details of the workshop to be worked out later. Provisions	4,00,000/-	4,20,000/-
	Total		**34,20,000/-**

Cost: Rs.34.20 lakhs

GOI approved for Rs.34.00 lakhs

3.12 Human Resources

3.12.1 Programme Management:

The SPMU & DPMU are the administrative head at State & District to plan implement & to monitor the NRHM programmes. The Administrative & Financial Professionals with required qualification & experience are to be inducted to SPMU & DPMU for smooth & effective functioning at State & District Health Societies.

3.12.2. The State Programme Manager & State Finance Manager are appointed during the end of 2007-08 and are provided supporting staff. During 2008-09 it is proposed to strengthen the SPMU by appointing State Data Manager & qualified supporting staff and also to procure additional equipments & transportation required for the office use. .

3.12.3. At the District level District Programme Managers were appointed during 2006-07 under and the Account assistant & Data entry operator taken under RCH and Immunization programme are assisting the District Programme Manager at DPMU. To strengthen further, the District Accounts Manager & Supporting staff with professional qualification is proposed for 2008-09.

3.12.4. In addition, the Block Programme Management Unit with BPM, Accountant & Data Entry Operator for effective implementation and collection of Data & Information at Block level is proposed.

3.12.5. With the induction of professionals at SPMU, DPMU & BPMU, the implementation of the programme will be smooth & effective.

3.12.6. The training programme for the Accountants at District and block level are proposed to orient the accountants on the programme and accounting procedure

3.12.7. Huge amount of fund is released to the district health societies and other spending centers for implementation. To enhance effective utilization of funds Concurrent audit is proposed from the year 2008-09.

3.11.8. Appointment of public health specialists

It has been observed that the district Health officers have to attend to a number of Administrative and other duties in addition to attending to all programmes. Presence of RCH officers and other programme officers does not decrease the public health/ management issues that the Dist. Health & FW Officer has to undertake. To help the DHO function in more effective MPH qualification on contract basis at a Rs. 20,000 pm in 29 districts, the total budget is Rs. 20000x29x12 = Rs.6960.00 lakhs

3.11.3. Appointment of hospital management specialists:

It has been observed that the District surgeon of Dist. Hospitals find it very difficult to manage the administrative and Hospital Management requirements of the hospital in addition to the clinical duties. Hence it is proposed to appoint with hospital management

and appropriate qualification to assist the District surgeon at a Rs. 20.000 pm to 24 dist. Hospital. The total budget is Rs. 20000x21x12 = Rs.50.40 lakhs

3.11.4. Consultants for RCH programme:

Five state level consultants are planned under RCH II programme. for Maternal health, Child health, Finance, M&E and for IEC At Rs.25,000/- pm.

3.11.5

Detailed Budget for the year 2008-09

Sl. No.	Budget Head	Physical Target			Rate (Rs/unit)	Amount (Rs.Lakhs)	Remarks
		Unit of measure	Base-line (Current status)	Target for the quarter			
1.	PROGRAMME MANAGEMENT						
2.	Strengthening of State Society/State Programme Management Support Unit						
3.	Contractual Staff for SPMU recruited and in position						
4.	State Programme Manager and State Finance Manager	Number	2	0	25000	1.50	
5.	State Accounts Manager State Data Manager	Number	2	0	20000	1.20	
6.	3Administrative Asst, 4 Accounts Asst. 2 Stastical Assist.	Number	9	0	7500	2.00	
7.	3 Computer Asst for SPMU Mission Director	Number	3	0	7500	0.70	
8.	3 Group ' D ' Employee	Number	3	0	4000	0.36	
9.	Furniture Equipments - Computers, Xerox, Scanner, Printing, UPS, etc.,	lumpsum	0	0	0	0.00	
10.	Hiring of 5 vehicles for SPMU staff to undertake topur for monitoring inspection of District Health Society and programme implementation at Rs. 30000/- per month per vehicle	Number	2	0	30000	2.00	

Sl. No.	Budget Head	Physical Target			Rate (Rs/unit)	Amount (Rs.Lakhs)	Remarks
		Unit of measure	Base-line (Current status)	Target for the quarter			
11.	Contingency expenses for stationary, post, telephone, TA/DA, Meetings, Office expenses etc.,	lumpsum	0	0	0	2.5	
12.	**TOTAL**					**10.26**	
13.	Strengthening of District Dsociety/District Programe Management Suppport Unit						
14.	Contractual Staff for DPMU recruited and in position						
15.	District Programme Manager - salary	Number	29	0	20000	17.50	
16.	District Accounts Manager - salary	Number	29	0	15000	13.00	
17.	Accounts assistant - salary	Number	29	0	7500	6.50	
18.							
19.	District Data Assistants - salary	Number	29	0	7500	6.50	
20.	D' Group Employee	Number	29	0	4000	3.50	
21.	Furniture Equipments - Computers, Xerox, Scanner, Printing, UPS, etc.,	lumpsum					
22.	Hiring of 29 vehicles for DPMU staff to undertake topur for monitoring inspection of programme implementation at Rs. 20000/- per month per vehicle	29	29	0	20000	17..40	
23.	Contingency expenses for stationary, post, telephone, TA/DA, Meetings, Office expenses etc., at the rate of Rs. 4 lakhs per district per year	Number 29	29	0	10000	8.70	
24.	**TOTAL**					**55.70**	

Sl. No.	Budget Head	Physical Target			Rate (Rs/unit)	Amount (Rs.Lakhs)	Remarks
		Unit of measure	Base-line (Current status)	Target for the quarter			
25.	Strengtheneing of Block Programme Management Unit						
26.	Block Programme Manager -salary	Number	176	0	10000	53.00	
27.	Accounts assistant - salary	Number	176	0	7000	37.00	
28.	Data Entry Operator - salary	Number	176	0	7000	37.00	
29.	Accountants to all PHC	Number	1679	0	7000	352.60	
30.	**TOTAL**					**479.60**	
31.	Strengthening of Financial System.						
32.	Training for District accounts Manager, Accounts Assistants at State, District, Block level Management Unit ie., around 1920 members	lumpsum				0.00	
33.	**Audits**						
34.	Annual Audit of all the District & State Health Society 30 Society approximately at Rs 30000/- per society	lumpsum				0.00	
35.	Concurrent audit at the District and State Societies at Rs. 4000/- per month	lumpsum	30	0	4000	3.60	
36.	**TOTAL**					**3.60**	
37.	**GRAND TOTAL**					**549.16**	

3.11.6. Budget:

E	Programme Management	NRHM flexi pool	RCH flexi pool
1	BPMU	508.00	
2	SPMU		42.57
3	DPMU		208.00
4	Strengthening of financial system	30.40	

E	Programme Management	NRHM flexi pool	RCH flexi pool
5	State consultants under RCH 2 PROGRAMME		15.00
6	Public health specialists to assist DH&FWO	69.60	
7	Hospital management specialists for 17 district hospital and 4 general hospitals	50.40	
8	Institutional Strengthening		22.25
9	Programme Management unit under RNTCP	10.00	
	Total	**668.40**	**287.82**

Cost: Rs.668.40 lakhs under NRHM flexipool and Rs.287.82

3.13 QUALITY ASSURANCE PROGRAMME

QUALITY ASSURANCE PROGRAMME IN 6 districts including TUMKUR DISTRICT

Tumkur District was selected as a pilot district for Quality Assurance programme in providing RCH Services in Sub Centres, PHC's & CHC's for the year 2007-08. Hence to launch the Quality Assurance Programme, a special budget provision has been made

3.13.1 Budget:

Cost of implementation of QA programme is estimated at Rs.8 .00 lakhs per district.

Total Cost of the programme: Rs.48.00 Lakhs

GOI approved for Rs.48.00 lakhs

CHAPTER – 4

PART-C of NRHM - IMMUNISATION

4.1 Background

Immunization is one of the most cost effective public health interventions to reduce mortality and morbidity due to vaccine preventable diseases. The successful eradication of small pox in the year 1978 using vaccine as an important tool promoted the global community to launch expanded programme of immunization (EPI) to control other vaccine preventable diseases. `EPI mainly focused on Diphtheria, Tetanus, Pertussis, Hepatities-B, Polio, Measles and childhood tuberculosis.

EPI in India was introduced in 1978 with the objective of reducing morbidity and mortality from Diphtheria, Tetanus, Pertussis, Hepatities-B, Polio, Measles and childhood tuberculosis. A key part of the programme was to establish self – sufficiency in vaccine production and develop a reliable cold chain system for storage and transportation of vaccine. In 2002 Hepatitis-B vaccination has taken as pilot project in 4 districts. And in 2008 it is been implemented through out the state.

Measles was included in the programme in 1985 and the programme was universalized and renamed as Universal immunization programme (UIP). The programme was introduced in a phased manner to cover all districts by 1990 with the aim of covering all infants with primary immunization schedule and pregnant women with TT. In 2005 government of India has introduced JE vaccine in Bellary, and in 2007 it is been introduced to 2 more districts Kolar and Raichur And JE is included in UIP in these 3 districts.

In the year 1992 with the launch of Child Survival and Safe Motherhood Programme (CSSM), Universal Immunization Programme was moved into CSSM functionally and managerially to become a part of a more integrated system and in 1997 it became an important component of Reproductive and Child Health Programme (RCH).

4.2 Situation analysis:

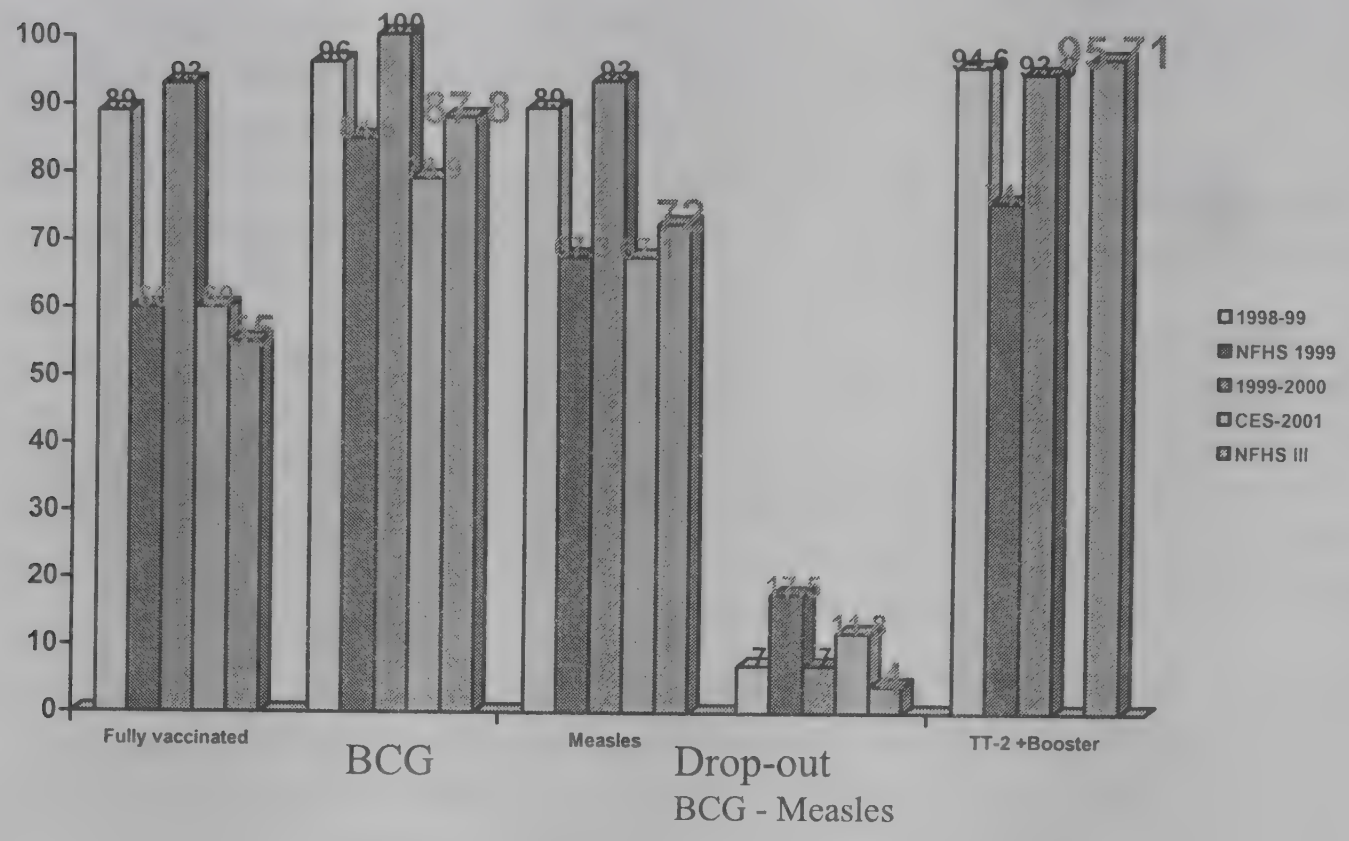
Reported immunization coverage for fully vaccinated children has shown an increase from 89% in 1998-99 to 88.79% in 1999-2000 and 101.05% in 2001-02 State high 2006-07 is 99%

Various evaluation surveys done during the same period have shown that coverage for fully vaccinated children as 60% (NFHS 1999) a difference of 29% between reported and evaluated coverage, 60% fully vaccinated (CES2001) 28.79% gap between reported and evaluated coverage.

The reported coverage for BCG during the same period was 96% ,100% and 111% , where as the evaluated coverage for BCG was 85% (NFHS 1999) a gap of 11% between reported and evaluated coverage , 80% (CES2001) a gap of 20% between reported and evaluated coverage.

Reported coverage for measles was 89%, 88.79% and 101.05% respectively. During the same time period, the evaluated coverage was 67% as per NFHS1999 and also CES 2001, a gap of 22 % & 21.79% between reported and evaluated coverage. As per NFHS III done in 2005-06 fully immunization 55%, BCG 87.8%, DPT III 74%, OPV III 73.8% &

measles 72%. And the reported coverage for 2006-07 is BCG 102.43%, DPT III 99.75%, OPV III 100.43% TT (PW) 95.71% & measles 95.30%.



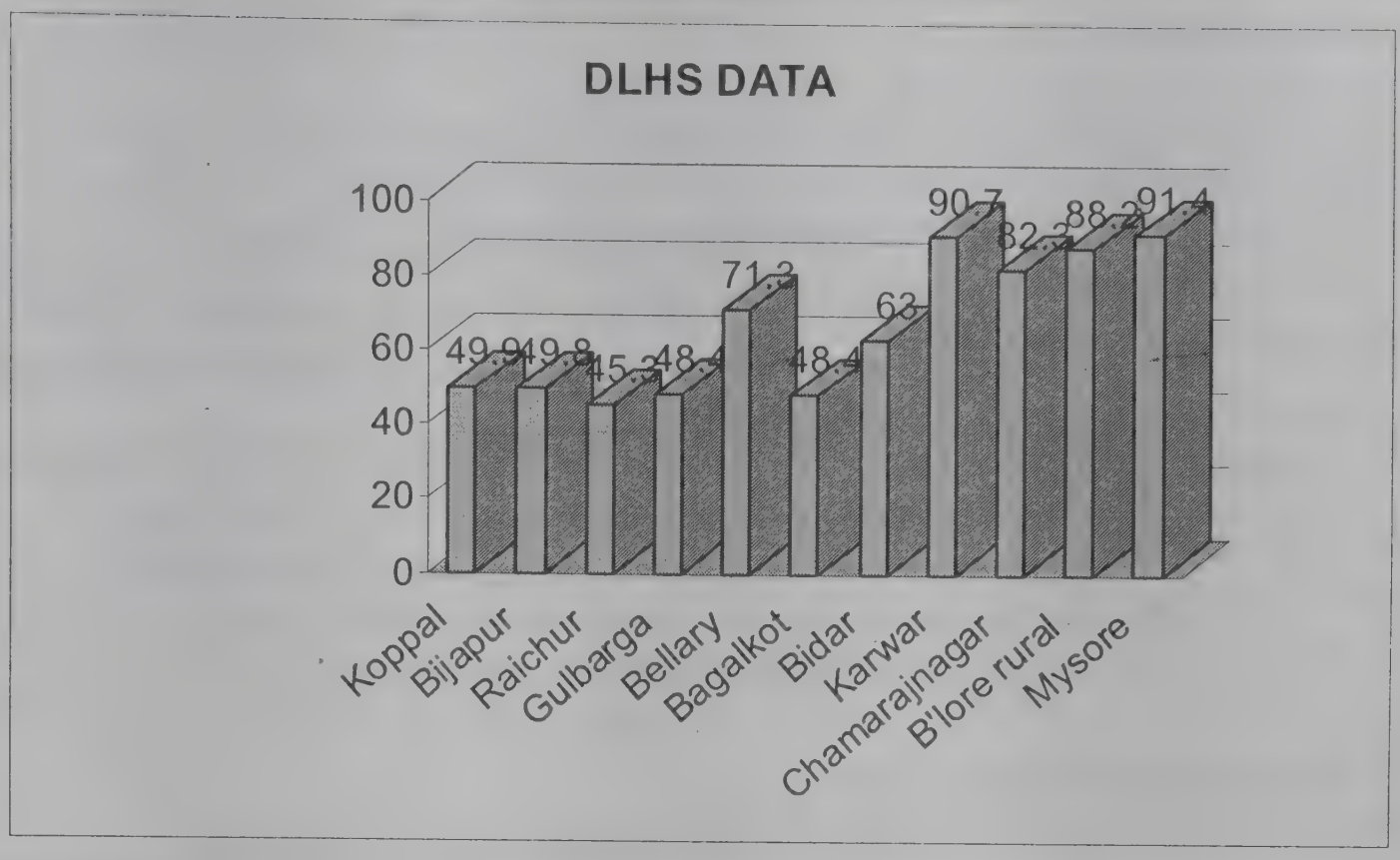
From this data it can be seen that although initial utilization (BCG) of immunization services is good, adequate coverage (Measles) is improved in the state as compared to NFHS II & NFHS III.

The drop-out rate between highest (BCG) to lowest (MEASLES) coverage antigen has been found to be 17.5% according to NFHS 1999 and 11.8% as per CES 2001 .These rates are particularly high given that an estimated 80% of the people live within 0.5 Kms of a scheduled session site. 2006-07 drop outs of BCG to Meseals is 4%.

Although overall immunization rates appear to be acceptable for the state, with in state, some districts have poor immunization rates and there is a clear divide between north and south Karnataka in comparison to immunization coverage.

Districts in south Karnataka have better immunization coverage when compared to northern districts. This is due to multiple reasons like high ill-literacy more so among women, poor awareness among parents about benefits of immunization and completing the immunization schedule, vacant posts, lack of resources for mobility, poor planning of immunization delivery services including outreach, shortage of vaccines at point of delivery and poor monitoring practices.

SOURCE: DLHS 2006-07 months



4.3. Reported and evaluated coverage

Comparison of Reported and Evaluated Coverage 1998-99 to 2006-07(%)

Antigen	Reported Coverage 1998-99	NFHS 1999	Reported Coverage 1999-00	CES 2001	Reported Coverage 2001-02	RHS 2 2003[2]	Reported Coverage 2003-04	Reported Coverage 2004-05	NFHS III	Reported Coverage 2006-07
Fully vaccinated	89	60.5	88.79	59.9	101.05	76	81.94	90.57	55	99
BCG	96	84.8	100	78.9	111.02	91.5	94.86	97.11	87.8	102.43
DPT-3	96		94		105.22	84.9	91.41	95.69	74	99.75
Measles	89	67.3	88.79	67.1	101.05	81.2	81.94	90.57	72	95.30
Drop-out BCG-Measles	7	17.5	11.21	11.8	9.97	10.3	12.92	6.54	4.0	7.13
TT 2 + booster	94.6	74.9	93.6		104.8	77.4	84.29	89.84		95.71

1.2.2 Vaccine preventable diseases.

Diseases	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
Measles	2143	1546	2401	3131	4804	5546
Diphtheria	6	162	21	42	15	1
Pertussis	NA	NA	2	NA	NA	NA
Neonatal Tetanus	5	3	2	11	0	2
Polio	36	1	Nil	233	0	1
TB cases below 5 yrs of age	-	-	-	-	0	0

Source: Govt of Karnataka.

4.4. Adverse Effects Following Immunization (AEFI)

No. reported in 2002 – 03:
No. reported in 2003 – 04:
No. reported in 2004 – 05:
No. reported in 2005 – 06
} NA

No. reported in 2006 – 07 : Two cases were detected (1 JE Vaccine, 1 DPT)
(Adverse Event Following Immunization committee has formed as supervisory committee for district committees)

Outbreaks of vaccine preventable diseases reported and outbreaks investigated in the last year. *(Elaborate)*

561 AFP cases were reported in Karnataka during last year which is above the expected AFP (217). Out of these reported cases stool collected within 14 days of onset was 84%, investigation within 48 hrs of notification was 91% , out-break response investigation was done in all cases.

4.5 Infrastructure & Staffing Levels

Infrastructure and health staff currently available is given below.

Health Staff

Position	Sanctioned Posts	In position	Proposed Addition	Trained in last 3 years
Medical Officers	3678	3147		Yes
Contractual Medical Officer	1391	1391		Yes
LHV (Female Multi-purpose Health Supervisor)	1389	1148		Yes
Male Multi-purpose Health Supervisor	1302	837		Yes
ANM (Female Multi-purpose Health Worker)	10255	9382		Yes
Male Multi-purpose Health Worker	5853	4594		Yes
Contractual ANM	-	245		Yes
Staff nurses	4717	4367		Yes
Pharmacists	2198	1791		Yes
BHEOs	531	491		Yes

All PHCs have been proposed with second doctor (AYUSH) and to have two staff nurses in all PHCs in a phased manner and to recruit ANMs on contract basis.

Dedicated Immunization Staff

Position	Sanctioned	In position	Proposed Addition	Trained in last 3 yrs
State Immunization Officer	1	1		NIL
State Statistical Officer	1	1		Yes
State cold chain officer	1	1	-	Yes
DIO	29	29	8	NIL
Cold Chain Mechanic / refrigeration mechanic	20	1		Nil
Driver (dedicated to UIP Vehicle)	74	74		

4.6 Vaccine Handler Training:

A total no of 2000 vaccine handlers (ANMs Pharmacist etc.,) will be trained during 2007-08 & 1500 will be trained during 2008-09. all DIO's, 150 MO's & all ANM's will be trained. This activity is being carried out as per approved PIP and funds already earmarked are sufficient.

4.7 Vaccine Transport (POL Etc Charges)

a) Central Store to Regional Store = Rs. 2.0 lakhs per year
b) Regional Store to District Store = Rs. 4.8 lakhs per year
10,000 X 12=4
c) District Store to PHCs 12,000X27 = Rs. 38.8 lakhs per year

4.8. Additional Support at State HQ

One Computer with Operator should be provided to the Cold Chain Officer for effective Vaccine Logistics and Cold Chain Management. One Computer & one laptop with Operator should be provided to the immunisation Officer for effective management.

Requirements of Various Cold Chain Equipments

Requirements of ILRs, Freezers for Taluka Hospitals for Sub-Divisional Storage

KARNATAKA	No of Taluka Hospitals	ILRs Big	Freezer Big	Voltage Stabilizer
TOTAL	176	354	354	762

Requirements of Cold Box, Vaccine Carriers, Spare Ice packs, Thermometers 2008-09

SL No	KARNATAKA	Cold Box22 lts		VC+ 4Ice Packs		Spare Ice Packs		Storage Thermometers Required	Voltage steblizers	
		S	R	S	R	S	R		S	R
	TOTAL	2522	905	49585	7950	434847	120000	3425	2026	3057
S- Supplied, R- Required, VC-Vaccine Carriers + Ice packs										

KARNATAKA	ILR Big		
	CFC	NCFC	Addl Requirement
	Supplied	Replacement	
TOTAL	33	110	93

KARNATAKA	Institution			ILR Small		
				CFC	NCFC	Addl Requirement
	PHC	CHC	TOTAL	Supplied	Replaced	
TOTAL	2260	299	1978	1392	1401	604

4.9 Cold Chain Storage Points

There is one state storage point (bulk store) at Bangalore and 6 regional stores.

A) One walk in freezer has been supplied to Belgaum will be installed shortly

B) One walk in freezer has been supplied to Gulbarga will be installed shortly

Urgent requirements.

1. The WIC installed in 1990 coming up for major repairs often due to the rusting & corrosion as salt action is in costal areas hence one WIC must be supplied urgently

2. WIC at Mysore was installed in 1987 this also needs replacement

Cold Storage Point	Total Number	Proposed Expansion
State store	1	Nil
Regional Storage	6	2(Mangalore & Mysore)
District store	29	Nil
Taluk Store	176	354 with Big ILR & FR, 762 stabilizers
ILR Storage Point	1978	604

4.10 Summary of recent initiatives

a) Service delivery improvements

Immunization sessions all over state are being conducted on Thursdays in all health centers but needs further strengthening. To strengthen out-reach sessions in six low performing districts, provision has been made to hire a vehicle.

b) Partnerships with other agencies / Organizations (e.g. ICDS, IAP, etc.)

ICDS has been a key partner for social mobilization in pulse polio and the partnership has been extended to routine immunization, most of the out-reach sessions are being conducted in anganwadis and anganwadi workers are playing a key role in informing the parents about the day of immunization and also in tracking missed out children. The sessions are planned in close co-ordination with ICDS. Although joint reviews are taking place at PHC level, taluk level and district level the partnership needs further strengthening. In some districts, IAP and medical colleges are carrying out immunization in urban slums and also in private clinics, the partnership needs further clarity for better delivery of immunization services. ASHA will also play major role in immunization & they will also track missed out children, informative care & to improve the immunization overall

c) UIP related trainings conducted in the last 3 years.

Position	No.
DIO (Mid Level Manager)	29
MOs	150
LHVs	Nil
ANMs	Nil
Sn. Health Assistants	Nil
Pharmacist	Nil
BHEOs	Nil
Other	-

4.11 Assessments of critical bottlenecks for full coverage.

a) Availability

Describe the main problems in the a) supply and distribution of vaccines and related supplies; b) availability of trained manpower for administrating vaccines.

The main problems in relation to availability are –

- ✓ From the regional stores vaccines are not lifted by districts on time due to various factors like break down in vehicle, shortage of POL etc.
- ✓ Another major challenge is availability of trained manpower for administering vaccines. Although most ANMs are trained during their course in basic concepts about vaccines, there is an urgent need for conducting refresher course on injection safety and techniques.
- ✓ Break down of cold chain equipments is another factor limiting availability of vaccines at service delivery level.
- ✓ No proper arrangements of sessions in urban areas, coverage is poor
- ✓ DIO is not properly planning the sessions in rural areas,

b) Accessibility

Describe the main problems in ensuring regular immunization sessions for all villages / urban slums

The main problems identified is -

- ✓ There is no functional RI micro-plan available with the districts indicating all villages and hamlets and how they are covered, this leads to some villages / hamlets being missed out from having immunization sessions.
- ✓ Hard to reach pockets with no proper travel facility.
- ✓ High vacancy of ANM.
- ✓ Lack of infra-structure in urban areas bring down greatly accessibility for immunization services.

c) Utilization / Adequate Coverage

Describe the main problems in ensuring high attendance (full coverage) in immunization session

The major problems identified in ensuring high attendance in immunization session are -

- ✓ No fixed day approach for visiting villages, as a result parents are not aware when the health staff will visit for conducting session, leading to missed out children.
- ✓ Lack of social mobilization.
- ✓ Shortage of vaccines , leading to cancellation of sessions
- ✓ Lack of sufficient manpower.
- ✓ Lack of supervision.

- ✓ Poor awareness among parents on benefits and completing immunization schedule.
- ✓ Lack of motivation among health staff.
- ✓ Poor maintenance of immunization records.

D) Effective Coverage / Quality

Describe the main problems in ensuring safe injections

The various problems in ensuring effective coverage / quality of immunization service delivery are –

- ✓ Health workers are not aware of correct dose and route of administration of vaccines.
- ✓ Poor awareness among health staff about cold chain and injection safety.
- ✓ In-adequate supply of syringes and needles.
- ✓ No re-orientation training after the staff passes out of ANM training schools.
- ✓ Poor maintenance of equipment.

4.12 Goals of Govt. of Karnataka:

- ✓ To ensure 100% immunization of all eligible children and pregnant women with required vaccines following standard practises.
- ✓ To sustain zero polio status.

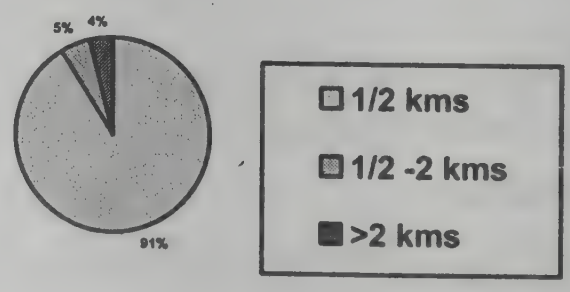
4.13 Objective:-

The overall goal is to increase immunization coverage rates. Based on review of past performance, assessment of critical bottlenecks, and planned activities indicate below the current (2004-05) and expected performance (2005-06)

In spite of discrepancies in reported and evaluated coverage, it is clear that a state wide system exists with the capacity and potential to deliver scheduled vaccines to eligible children.

80% of children live within ½ kilometer from a session site, indicating distance is a minimal constraint, while ensuring implementation of scheduled session is more likely problematic.

It has been observed that if sessions are held regularly as per the micro-plans and if we are able to reach these readily accessible children with quality immunization services, significant impact on coverage can be achieved (estimated at 12% increase.)*



Source: Immunization service assessment.

Immunization Coverage Targets:

Indicator	CES 2001 (Evaluated)	Planned 2007-08	Planed 2008-09
BCG coverage (%)	78.9	90%	100%
DPT-1 coverage (%)	77.6	90%	100%
DPT-3 coverage (%)	75.3	90%	100%
Districts with over 80% DPT-3 coverage No. - (%)		100%	100%
Measles coverage (%)	67.1	80%	100%
Vit A coverage (% 2+ doses)			100%
Districts with over 70% vit A coverage- No. (%)	74%	100%	100%
Drop-out rate BCG – Measles (%)	11.8	< 5%	<2%
Districts with under 15% BCG Measles Drop Out – No. (%)			Nil
Children fully vaccinated by 12 months of age (%)	53.3	80%	100%
TT 2 + B coverage (%)			100%
Districts with over 90% TT2 + B coverage – No. (%)		100%	100%

*** Immunization service assessment**

4.14. PROGRAMME ACTIVTIES PLANNED FOR STRENGTHENING ROUTINE IMMUNIZATION IN 2008-09 – KARNATAKA

- ✓ All districts will have good quality operationally implementable micro-plans for routine immunization both in urban and rural areas.
- ✓ Ensure 100% availability of vaccine and AD- syringe supply in all districts based on supply schedule.
- ✓ Capacity building workshop on routine immunization for RCH officers & medical officers on areas such as management, including supervisory skills and technical issues appropriate to their levels
- ✓ Training of frontline functionaries in basic concepts about immunization, use and safe disposal of AD –syringes and use of hub cutter.
- ✓ Ensure functional cold chain status in all districts to above 90% by creating a team of trained staff at PHC and though annual maintenance contract (AMC)
- ✓ Improve immunization coverage in 29 districts by ensuring regular quality sessions and social mobilization though anganwadi workers and by making provision to hire ANMs to conduct immunization sessions in vacant sub-centers.

- ✓ Strengthen urban immunization coverage by building public-private partnership involving medical colleges, nursing colleges, ANM training schools, IAP, Rotary, NGOs and though contractual ANMs.
- ✓ Ensure high quality supervision of immunization sessions by all levels of officers.
- ✓ Implement internal evaluation of immunization programme in all districts by training medical officers, DHOs, RCH-O, Taluk health officers and all state level officers.
- ✓ Half yearly review of immunization programme at state level to take mid-course corrective action.
- ✓ Implement RIMS in all districts, data collected to be used for programmatic improvements.
- ✓ SNID in high risk 11 Northern Karnataka Districts bordering Maharashtra conducted on 12th November 07 & May 07.
- ✓ Strengthen and improve surveillance though better case identification and reporting.

4.15 Improve Vaccine / Supply Logistics

Govt. of India to ensure timely supply of vaccine and AD syringes thoughout the year. Vaccine distribution schedule will be developed and implemented at all levels.

Distribution of vaccines from state to regional store on quarterly basis – Jan, April, July & Oct and regional stores to maintain 3 months buffer stock.

Vaccines to be distributed monthly (1st week) to districts from regional stores and districts to maintain 1 month's buffer stock. Similarly PHCs should lift required vaccine with 1 month buffer stock from the district by 1st week of every month.

Regional stores should send vaccine stock balance to the state by first week of every month and all districts to lift vaccines only from the concerned regional store.

Separate POL budget will be allocated to state cold chain cell for distributing vaccines to regional stores and for districts to lift vaccines from regional stores.

4.16. Key Performance Indicators

Indicator	Current 2004-05	2005-06	2006-07	2007-08
Districts with any antigen stock-out (nil stock) more than 1 month in the last 12 months (2004 05) -No. (%)	Nil	Nil	Nil	Nil
Districts with AD syringe stock-out more than 1 month in the last 12 months – No. (%)	Not Applicable.	Nil	Nil	Nil

4.17 Expand Cold Chain Reach and improve performance

Data available on the non-functional status of ILR & DF shows that 1.2% of ILR & Freezers are non-functional and repairs are on going.

There has been no cold chain assessment under-taken in the state since past three years and it is planned to under-take one cold chain assessment during the current years 2007-08 & 2008-09.

The detailed proposal of expansion and the budget required for cold chain assessment has been enclosed in Annexure

4.18. Key Performance Indicators

Indicator	**Current 2007-08**	**Planned 2008-09**
Cold Chain assessment done within last 3 years (exact year done or planned)	**1**	**1**
Proportion of ILR registered (not condemned) non-functional (%)	**1.2%**	**Nil**
Proportion of DF registered (not condemned) non-functional (%)	**1.2%**	**Nil**

4.19 Ensure all children in all villages / towns Covered with regular (monthly / quarterly) immunization session according to village size.

The process of preparing template for routine immunization micro-plan has been taken up by operational core group for routine immunization established at state level. Guidelines on how to use the template will be developed by the core group and the template with guidelines will be circulated to all districts.

The micro-plan template will not only capture villages / habitation wise sessions planned but also the health staff / health institution assigned a particular population / urban area , the expected number of beneficiaries , vaccine requirement per session and the number of AD syringes required for these sessions.

4.20.Key Performance Indicators

Indicator	**Current 2004-05**	**2005-06**	**2006-07**	**2007-08**
%districts with routine immunization micro-plan (sub-centre plan) available	Nil	100%	100%	100%
% urban areas with routine immunization micro-plan available (including involvement of Private practitioners and medical colleges	Nil	100%	100%	100%
%Village (over 1,000 population) covered 1 or more times a month	100%	100%	100%	100%
%village (under 1,000 population) covered 1 or more times a quarter	100%	100%	100%	100%
%Slums / high risk areas covered monthly	50%	75%	75%	80%
%Sessions planned versus sessions held	Nil	Nil	100%	100%

Source of date: Govt. of Karnataka

4.21 Improve injection safety by introducing AD-syringes

With the introduction of AD syringes there is a need to develop AD – syringe and hub cutters supply schedule. The procedure used for vaccine supply to regional stores and in turn to districts will be utilized for supplying the AD Syringes & hub cutters.
The quantity of AD – Syringes & hub cutters supplied will be based on requirements sent by districts based on the annual targets. One day training of all health functionaries in use and safe disposal of AD syringes will be done.

All PHCs and CHCs will have safe disposal pits constructed as per guidelines. The money for construction of pits will be given to taluk health officer though proper channel and it will be the responsibility of taluk health officer to certify and send a letter to the state that pits are constructed as per the guidelines.

4.22. Key Performance Indicators

Indicator	Current 2004-05	2005-06	2006-07	2007-08
PHCs using AD Syringes for all immunizations (%)	Nil	100%	100%	100%
PHCs with appropriate waste disposal in place (safety pits) (%)	Nil	100%	100%	100%

4.23 Ensure accurate record-keeping / monitoring with improved supervision

For monitoring routine immunization programme, standard checklist with guidelines will be developed by operational core group established at state level. This checklist will be used by state level officers, district level officers, taluk health officers and medical officers for monitoring immunization service delivery.

The data collected will be analyzed at the end of each month at district level and analyzed data along with the corrective actions taken will be sent to state level with in first week of every month

Reduction in cancellation of sessions with better planning and supervision and avoiding duplication of data reporting will help in reducing the gap in reported and evaluated coverage.

Half yearly meeting of DHOs, RCH-O will be held at state level for review of immunization programme and to take mid –year corrective actions.

Adequate MCH registers, vaccination cards and monitoring formats will be supplied to districts from the state.

Uniform vaccine & AD syringes issue register has been developed by operational core group established at state level. This register will indicate the issue of vaccines and AD syringes for each session and the template will be supplied to the districts.

Key Performance Indicators

Indicator	Current 2004-05	Planned 2005-06	2006-07	2007-08
Gap between reported and evaluated full immunization coverage (%)	28.89*	< 10%	<7%	<5%
SCs maintaining counterfoils of vaccination card (%)		100%	100%	100%
SCs maintaining vaccination registers (%)		100%	100%	100%

*** Difference in reported coverage 1999-2000 and CES 2001.**

4.24. Train immunization Staff

Two days training of medical officers will be conducted at district level. The areas covered will be –

- ✓ Planning & implementing immunization services effectively.
- ✓ Proper management of inventory at PHC level.
- ✓ AD syringes and their disposal.
- ✓ Use of checklist for monitoring immunization sessions & SC visits.
- ✓ Data collection, analysis and use of data for better programme management.
- ✓ Vaccines & Vaccine preventable diseases and recent developments.
- ✓ Strengthening monthly reporting of PHC data.
- ✓ Management of AEFI.
- ✓ Management of bio medical waste
- ✓ Regular data transfer
- ✓ Identification of drop outs & missed out children.

Three days training of ANM & LHV will be organized at taluk level and the topics discussed will be –

- ✓ Basic concept on preparing micro-plans and importance of up-dating it every year.
- ✓ Basic concept about vaccines & VPDs.
- ✓ Proper maintenance of immunization registers, immunization cards.
- ✓ How to make immunization pouches to store counterfoil of immunization card and use for drop-out tracking.
- ✓ Practical demonstration of Injection techniques.
- ✓ How to use AD syringes, needle cutter and safe disposal of waste.
- ✓ Strengthen data reporting with better reporting of AEFI and VPDs.
- ✓ Identification and how to respond to AEFI.
- ✓ Building better co-ordination with Anganwadi & ASHA workers & other counter parts for better service delivery.

Key performance Indicators

Indicator	Current 2004-05	2005-06	2006-07	2007-08
ANMs having received refresher training in immunization within that last 3 years (%)	Nil	100%	100%	100%
MOs having received training in immunization within that last 3 years (%)	Nil	100%	100%	100%
DIOs having participated in mid-level managers (MLM) training within the last three years (%)	Nil	100%	100%	100%

4.25 Action Plan[3]

1 Alternative Vaccine Delivery

As per guidelines laid down, outline action points for implementing delivery scheme at district / taluka level, justifying district or taluka specific divisions from the established norms.

Arrangements will be made to deliver vaccine from PHC to all session sites of sub-centers other than those sub–centers which are located in PHC head quarters. Amount of 200 Rs per sub-center will be paid for transporting vaccine.

The money will be given to medical officer though proper channel for distribution. The decision of appointing the person to transport vaccine and ensuring vaccine is delivered to session site in time will be the responsibility of medical officer. Vaccine distribution plan and the name of the person who will distribute the vaccine will be included in the micro-plan

The person transporting the vaccine should have his/her own mobility either in the form of two wheeler / cycle. Not more than one PHC will be given to one person for vaccine distribution. Detailed budget requirement is enclosed in annexure.

2 Mobilization of children

Outline social mobilization plans using AWW or other link worker within the prescribed funds (Rs. 100/month / village)

As per the available evaluated data (MICS-2002) it is clear that immunization coverage is poor in northern Karnataka districts .To improve immunization coverage and to reduce drop-outs, social mobilization will be done through anganwadi worker or through self help groups in all districts. Each anganwadi worker / self help group member will be paid 100 Rs per month for the activity (Shown in annexure 2).

Urban areas have been a major challenge for improving routine immunization services, this is mainly due to lack of infrastructure of both health and ICDS in urban areas. As a result lots of children are missed out since the community is not aware of when the immunization will take pace in the slums / under served areas.

To over-come this disadvantage in urban slums one social mobiliser will be appointed for every 2500 population. They may be anganwadi worker where ever available or self help group or link workers or any NGO which is working in the same locality. They will be responsible for bringing children for sessions and also will help in converting resistance. They will be paid Rs 100 per month for the activity. The detail budget has been enclosed in annexure.

3. Slums & Underserved areas

Plan for immunization sessions in urban areas. National guidelines provide Rs. 1,400/month per slum of 10,000. Scheme may provide funds to contract an ANM / NGO to implement activities or alternative arrangement. Again provide details for the total allocation required as well as roles and responsibilities and monitoring.

One session for every 2500 population will be held in urban slums / underserved areas and in earlier PPC covered areas. The responsibility to carry out session will be given to any of the partners given below as per the availability at the district –

- ✓ Medical colleges.
- ✓ Nursing colleges
- ✓ ANM training schools.
- ✓ Hiring of retired ANM / LHV.
- ✓ NGOs.
- ✓ IAP, IMA etc.

Training, Monitoring and supervision of the staff working in these allotted areas will be done by concerned district RCH – O, THO and if available medical officers of urban centers.

The monthly report on performance in these allocated areas will be submitted to the concerned area medical officer, if there is no urban health centre, reports will be submitted to concerned taluk health officer. Also it will be made mandatory to attend monthly meeting at either of the places.

Wherever Govt health set-up exists in urban areas, the existing ANM will be given a population of 5000 for immunization service delivery and the remaining area will be allocated to partners for conducting immunization.

The detailed budget requirement is enclosed in Annexure.

4 Strengthening monitoring and supervision and surveillance

Outline plans for the provision for POL / maintenance to be administered by DIO. A total of Rs. 50,000 / district / year & 25000/ THO / year to be allocated.

Each RCH – officer will be given an annual budget of Rs 50,000 for POL. A standard checklist will be developed by operational core group established at state level for monitoring immunization sessions and visits to PHC and sub – center.

The data collected will be analyzed at district level and the corrective steps taken will be sent to state by the end of first week of every month for compilation at state level. The compiled data will be analyzed and problems identified will be discussed for improving programme management in operational core group meeting which will be held once in 15 days at state level.

5. Computer assistant to DIO

A provision of up to Rs. 10000/ month is available to employ a computer assistant for the DIO. If planned for Districts & talukas, describe recruitment process of these persons and the terms of reference.

All 29 districts in Karnataka will have one computer assistant which will be provided for RCH officer exclusively for immunization purpose. Computer assistant will be recruited locally by district health officer, he should have excellent skills in micro-soft office (i.e, MS- Word, MS –Powerpoint . MS – Excel & MS –Access).

He will be responsible for collecting reports/ data from taluk level and compile the data at district level and maintain computer data base of all indicators related to immunization. In addition to computer assistant at district level, one computer assistant will be taken at state level for collecting, compiling data of all 29 districts and maintenance of computer data base.

→ **Introduction of RIMS software for monitoring UIP.**

GOI has contracted an external agency to prepare and introduce "RIMS" computer software into all districts. A provision has been made to train up to 5 persons / district. Indicate plans for this initiative.

All recruited computer assistants will be given hands on training at state level for one day on use of RIMS software. All districts will implement RIMS and data analyzed by using RIMS will be forwarded to state level. but it is not in progress because of technical problems.

6. Review meetings

State whether review meetings will be held with provided allocation and the frequency. Half yearly review of progress in immunization will be done at state level. This meeting will be attended by DHO, RCH-O and DNS of all 29 districts. Details of the budget requirement have been enclosed. In addition to this the operational core group established at state level will meet once in 15 days and will analyze the district wise data and feed-back on corrective actions needed will be conveyed to the districts.

7. Provision for additional support

3.7.1 Vaccine Supplies

Complete included annexes (1a & 1b) to determine the annual District-wide vaccine requirement.

Detail requirement of vaccines has been enclosed in annexure

Detailed GOI guidelines are available as annexure to this template.

3.7.2 Strengthening cold chain

Attachment annex (2) to summarize the overall requirement for the coming year. Below provide Justification / explanation of the proposed activity.

- Replace CFC equipment with non-CFC equipment[4]

  There is a need to replace 405 small and 30 big CFC equipped DF with non-CFC equipped Deep freezers.

- Replacement of non-functional (beyond repair) equipment

Estimate and explain number of equipments that may need to be replaced in 2005-06. In the annex, also estimate the percent of equipment that will require replacement in subsequent years.

Explanation of Cold Chain Storage points[5]

Explain needs and plans depending on the setting up of New PHC and/ or special needs (e.g. extremely remote area)

There is one state storage point and 6 regional stores. Additional walk in freezer has been proposed to be set up in Gulburga by 2006-2007 and 1 WIC in Bijapur / Bagalkot .Currently out of 1681 PHCs 1422 have ILRs it has been proposed to equip the remaining PHCs with 259 ILR& 679 DF in the year 2005-2006. It has been proposed to equip all 299 CHCs with ILR & DF by the year 2006-2007 and 581 PHUs by 2007-2008 so that distance traveled to collect vaccines is brought down. All 176 taluks which have small ILR & DF now will be equipped with bigger ILR & DF by 2006-2007 to increase the storage capacity.

3.7.3 Cold Chain maintenance

→ **Cold Chain Technicians**

Provision can be made for 1 cold chain technician per district. Indicate if technicians already in place or will be newly recruited.

→ **Maintenance Fund.**

A total of Rs. 500 per ILR should be budgeted for spares and other maintenance requirements. Plans should indicate how funds will be disbursed and plans for management of spare parts.

For maintenance of cold chain equipment annual maintenance contract has been in process .AMC will be given division wise for better management.

The total funds required for maintenance of ILR, WIC, WIF, voltage stabilizers and district fund is estimated 2500000/-

3.7.4 AD syringes

The total AD syringes requirement should be outlined in vaccine supply format provided.

The total requirement of AD- Syringes has been enclosed.

3.7.5 Printing and dissemination of tally sheets

Supply mother-child card / vaccination card / plastic jacket for the cards. Total requirement should be indicated in vaccine supply requirement – as will be printed and supplied by the Central Government.

The budget for printing of immunization cards and MCH register has been included under State RCH II -PIP. The budget requirement for printing standard operating procedures to be given to all medical officers , micro-plans , vaccine & AD – Syringes issue regsiters and monitoring sheets has been is enclosed.

3.7.6 Re-orientation of ANMs

A provision is made for 3-days refresher training to all ANMs, LHVs, and male health workers. A total of Rs. 350 per participant has been allotted. If planned, outline schedule of training and implementation responsibilities.

Three days training of ANMs has been planned, the training will take place at taluk level and the responsibility of training will be with district health officer , district RCH –

officer , programme officers & Taluk health officers. The details of the points covered in this training are as follows –

- ✓ Basic concept on preparing micro-plans and importance of up-dating it every year.
- ✓ Basic concept about vaccines & VPDs.
- ✓ Proper maintenance of immunization registers, immunization cards.
- ✓ How to make immunization pouches to store counterfoil of immunization cards and use for drop-out tracking.
- ✓ Practical demonstration of Injection techniques.
- ✓ How to use AD syringes, needle cutter and safe disposal of waste.
- ✓ Strengthen data reporting with better reporting of AEFI and VPDs.
- ✓ Identification and how to respond to AEFI.
- ✓ Building better co-ordination with Anganwadi workers & other counter parts for better service delivery.

3.7.7 Additional trainings

- **Refresher training to DIO / Regional Store on supply formats**

A 1-day training to DIO / cold chain officers on rationale and procedures for filling-up required formats (TOT). Provide refresher training on cold chain maintenance and procedures to follow in case an extended power-cut.

Two days state level capacity building workshop for RCH officers on areas such as management, including supervisory skills and technical issues on routine immunization, cold chain maintenance, use and safe disposal of AD –syringes and recent developments in immunization will be conducted.

In addition to this one day state level training on how to plan and conduct internal evaluation of immunization programme of all state level officers, district health and RCH officers has been planned.

The detail budget requirement has been enclosed.

All CFC equipments supplied till 1993 should be replaced with non-CFC equipment. The expansion plan should include replacement of remaining CFC equipments supplied during period of 93-98. If all equipment has already been replaced, remove this section.

National norms for vaccine storage provide 1 ILR / Small + 1 DF/Small per PHC (last storage point). Large ILR / DF are intended for taluks and district HQ only.

Training of Cold Chain Technicians.

Refresher training to cold chain technicians (2 days) could be planned every two years. Benchmark estimate is 1,700 per participant (1,000 travel + 2 x 250 per diem + 2 x 100/day material cost).

One day district level training on cold chain for vaccine handlers will be done. The participants will comprise of four persons from each PHC- LHV, HQ ANM, and Staff nurse / SHAM (Sr. Health Asst. Male) & Pharmacist. This will allow for creation of a team of trained people at PHC level which will lead to better cold chain management.

The detail budget requirement has been enclosed.

Summary of all UIP-related training activities, 2008-09

Training date	Target Group	No. of participants	No. of batches	Duration	Remarks
16 -9-08 & 17-9-08	RCH officers	27	1	2 days1	Training will be conducted at State level
19 to 24-9-08	Medical officers	3661	101	2 days	Will be done at district level .
3 to 15 –10 -08	ANM & LHV	19994	500	3 days	Training will be held at taluk level.

3.8 District-specific strategies.

Outline other plans at District level including those that are funded by District resources as well as those schemes where central funding support is requested. Suggested thematic areas for presenting district strategies include:

- ✓ All districts will have uniform micro-plans and vaccine & AD syringe issue register for routine immunization.
- ✓ All districts will be provided POL support to lift vaccines from regional stores.
- ✓ Social mobilization will be done in all districts through anganwadi & ASHA worker / SHG.
- ✓ AD-syringes will be utilized for all vaccines and health staff will be trained in use and safe disposal of AD –syringes.
- ✓ Supervision will be strengthened by developing checklist for visits to PHC, SC and immunization session, the data will be consolidated at district level and corrective actions taken will be sent to state within 1st week of the month.
- ✓ Reporting of VPDs will be strengthened by conducting capacity building workshop for all health staff in identifying VPDs and ensuring prompt monthly reporting.
- ✓ Internal evaluation will be done at the end of year in all districts which will mainly focus on availability, accessibility, initial utilization, adequate coverage and effective coverage of immunization services.
- ✓ Community based research activity on VPDs has been planned to be undertaken in the coming year.
- ✓ Urban area immunization services will be strengthened by utilizing the services of medical colleges , nursing colleges , ANM training schools , IAP etc , and social mobilization will be done by SHG's / AWW.
- ✓ Implementation of Hepatitis B vaccination.
- ✓ JE vaccine implementation.

→ Microplan
→ Cold Chain
→ Vaccine Logistics
→ Service Delivery
→ Social Mobilization
→ Injection Safety
→ Supervision
→ Surveillance
→ Evaluation
→ Research
→ Urban areas

3.8.1 Funded by State Budget

Outline UIP activities that are being funded with state budgetary support.

3.8.2 Funded by State Development Partners

Outline UIP activities that are currently funded by state development partners (e.g. WHO, UNICEF, bi-lateral donors, NGOs, etc.).

3.8.3 Additional Schemes requiring Additional Funding from Central Government

Describe plans and financial requirement for additional UIP acceleration plans.

1) Awards to Jr health asst (F) those who have achieved 100% immunization in assigned area. Per district 10 members x 29 district x 5000/-per Jr health asst (F).
2) Awards for the field as well as MO's who has served the best in the immunization program
3) Awards to public private partnership those who have achieved the best targets
4) Complete implementation of RIMS in the state for better monitoring & evaluation and to improve the reporting system

4 Annexes

1. Vaccine supply plan (plus vaccine requirement worksheet)
2. Cold Chain Plan
3. Budget

a. Budget variables used

b. UIP Budget Detail (detailed costs by funding / purpose source)

c. UIP Budget Heading Summary (by accounting budget heading, % of total)

4. Guidelines for GOI immunization Scheme.

A. Existing Support for state -

Sl No	Item	Additional Requirement				
		Existing	2005-06	2006-2007	2007 - 2008	2008-2009
1.	a) Cold Chain:					
	→ WIC	7		1	1	2
	→ WIF	2		1	1	
	→ ILR (+/ - 300 lits)	110		176	93	93

Sl No	Item	Additional Requirement				
		Existing	2005-06	2006-2007	2007 - 2008	2008-2009
	→ DF (+ / - 300 lits)	182		176	103	103
	→ ILR (+ / - 140 lits)	1401	259	299	361	390
	→ DF (+ / - 140 lits)	997	679	299	597	557
	→ Cold Boxes (+ / - 20 lits)	2522	275	340	905	905
	→ Cold Boxes (+ / - 5 lits)	1166	116	128	500	500
	→ Vaccine Carrier	49585	3199	3519	7950	7950
	→ Ice Pack	456000	13510	14861	120000	120000
	b) Funds for cold chain maintenance	1200000	1257500	1383250	2500000	2500000
	c) Vaccine Van	13	16	5	5	5
2	Logistics					
	Glass syringes & needles (Will continue in 2005-06)					
	KOL (Will continue in 2005-06 only @ Rs. 20/- Sub-centre/month)					
3.	Vaccine - This will be provided by GOI					
4.	Support for Computer Assistant at District Level	Nil	28	28	28	30
5.	Support for Review Meetings in rupees.	Nil	202500	222750	245025	269528

Budget:

Sl. No.	Particulars	Amount
1.	Mobility support for supervision	Rs. 14.50 lakhs
2.	Mobility for nodal officers (M&E)-	Rs. 1.16 lakhs
3.	Alternative vaccine delivery –	Rs. 240 lakhs
4.	Focus on slum & under served areas-	Rs. 92 lakhs
5.	Mobilisation of children through AWW/AW helper/ASHA and SHG members	Rs. 360 lakhs
6.	Training for ANMs/LHVs/BHEOs at district level-.	Rs. 56 lakhs

Sl. No.	Particulars	Amount
7.	Training for MOs at district level	Rs. 29 lakhs
8.	State level training for DIOs-	Rs. 1.00
9.	Review meeting at state level –biannually-	Rs. 2.6 lakhs
10.	Computer assistant at state level-	Rs. 1.01 lakhs
11.	Computer assistants to DIOs –	Rs. 34 lakhs
12.	Computer assistant under SIP-	Rs. 1.00 lakh
13.	•POL for vaccine delivery from state to regional store-	Rs. 6.6 lakhs
14.	•POL for districts to lift vaccines from regional stores	– Rs. 8.98 lakhs
15.	Printing of operational guidelines and check lists, immunisation cards, registers, tikler box	Rs. 100 lakhs
16.	Cold chain	
17.	•Cold chain maintenance-	Rs. 25.00 lakhs
18.	•Reconditioning of WIC/WIF	Rs. 4.5 lakhs
19.	Printing of CC formats, guidelines & sickness reporting pads-	Rs. 15 lakhs.
	Total	**Rs. 988.35 lakhs**

GOI approved for Rs.983.00 lakhs

CHAPTER - 5

Part - D

Disease Control Programmes

5.1. INTEGRATED DISEASES SURVEILLANCE PROJECT (IDSP)

5.1.A. Part-I

5.1.A.1. Project Objectives

To establish a decentralized state based system of surveillance for communicable and non-communicable diseases, so that timely and effective public health actions can be initiated in response to health challenges in the country at the state and national level.

To improve the efficiency of the existing surveillance activities of disease control programs and facilitate sharing of relevant information with the health administration, community and other stakeholders so as to detect disease trends over time and evaluate control strategies.

5.1.A.2. Specific Objectives

- To integrate and decentralize surveillance activities.
- To establish systems for data collection, reporting, analysis and feedback using Information Technology.
- To improve laboratory support for disease surveillance.
- To develop human resources for disease surveillance and action;
- To involve all stakeholders including private sector and communities in surveillance.

5.1.A.3. Project Activities

A. Up gradation of Laboratories

- Renovation & Furnishing of labs.
- Supply of Lab Equipments.
- Lab. Material and Supplies.

B. Information Technology and Communication

- Computer Hardware & Office Equipments
- Software for surveillance.
- Leasing of Wide Area Networking.

C. Human Resources & Development

- Consultant/ Contract Staff.
- Training.
- Information, Education & Communication.

D. Operational Activities & Response Monitoring & Evaluation Diseases covered under IDSP Regular Surveillance

1. Malaria.
2. Acute Diarrhoeal Disease (Cholera)

3. Typhoid.
4. Tuberculosis.
5. Measles.
6. Polio.
7. Road Traffic Accidents (Linkup with Police computers)
8. Plague.
9. Meningoencephalitis/ Respiratory Distress, Hemorrhagic fevers, other undiagnosed conditions.

Sentinel Surveillance

10. HIV/HBV, HCV.

Other Conditions

11. Water Quality, Flurosis.
12. Outdoor Air Quality (Large Urban Centres)

Regular periodic survey

13. Anthropometry, Physical Activity Blood Pressure, Tobacco, Nutrition, Blindness.

State Priority deseases.

14. Filariasis.
15. Kyasanur Forest Disease.
16. Handigodu Syndrome.
17. Leptospirosis.

E. Reporting Units for Disease Surveillance

Rural	Public Health Sector	Private Health Sector
	PHCs / CHCs / Sub-district and District Hospitals	Sentinel Private Practitioners and Sentinel Hospitals
Urban	Urban Hospitals, ESI, Railway, Other Hospitals Medical Colleges.	Sentinel Provate nursing homes, Sentinel Private Medical Colleges NGOs, Private Laboratories.

F. Involvement of Private Sector

- Strategic Alliance through Professional Association (IMA,IAP).
- Selection by volume of target diseases, geographical coverage, credibility and willingness to participate.
- Providing linkages through web or Transmission by e-mail, Fax/telephone/courier.
- Recognition and Partnership.

G. Aims of NCD risk factors surveillance

NCD Survey

NCD survey has been a part of IDSP project and Government of India has accepted the proposal to state to take up 1-year piolet project in the

1. Monitor trends of important risk factors of NCD in the community over a period of time.
2. Evolve strategies for interventions of these risk factors so as to reduce the burden of diseases due to non-communicable diseases.
3. Strengthen NCD Surveillance at District level.
4. Integrate NCD risk Factor Surveillance with IDSP.

H. NCD risk factors:

Behavioral

1. Tobacco and Alcohol use.
2. Dietary habits

Physical

1. Levels of physical inactivity

Biochemical Assessments

2. Blood Sugar
3. Blood Cholesterol

Measurements

1. Height, Weight
2. Pulse rate
3. Blood pressure
4. Waist Circumference.

5.1.B. Part - II

Budget Proposal for IDSP Component under NRHM during Fy : 2008-2009

5.1.B.1. Repairs and Renovations of State Surveillance unit, District Surveillance Unit/ District Laboratory etc.

The District Surveillance unit laboratories were renovated under IDSP with Govt of India funds. However some of the District DSUs require some repairs and maintenance. The DSUs at Bidar and Gulburga requires repairs of roof leaking etc. The required budget will be released on case-to-case requirement.

Hence a provision of **Rs. 40.00 lakhs** is proposed during Fy 2008-09.

5.1.B. 2. Laboratory consumables & reagents

The Microbiologists and laboratory technicians have been trained to conduct tests for Communicable Diseases. They have been given list of recurrent and non-recurrent consumables. Since Laboratories are already supplied with Elisa reader and washer, all these laboratories have to be supplied with reagents, chemicals and testing kits for conducting Dengue, Chikungunya, JE, and Hepatitis tests etc.. It is proposed to make a budget provision @ Rs 1.5 Lakhs / DSUs and for Public Health Institute for Laboratory consumables & reagents.

Hence a provision of **Rs. 43.5 lakhs** is proposed during Fy 2008-09.

5.1.B.3. Operational Cost: Printing of forms and registers

Under IDSP all the Sub Centers (approx. 8160) have to send S (Syndromic)reports forms every week .The P (Presumptive) forms will be generated from al the Public Health facilities and some of the Private Health Institutions. The details of the patients will be maintained in the respective registers in the Health Facility. There is need to supply Presumptive (P), Syndromic (S) and Laboratory (L) registers and forms to the Sub Centers, PHCs, CHCs, General Hospitals, District Hospitals, Private institutions(approx. 2500). The funds will be released to respective DSUs in phases for implementing the activity.

Hence a provision of **Rs. 42.00 lakhs** is proposed during Fy 2008-09.

5.1.B.4. Elisa Reader and Washer

Only Six laboratories in Karnataka have been supplied with Elisa reader and washer. Further IDSP proposes to supply at the Elisa reader & Washer to all the balance 23 District Surveillance Units (including Bangalore Urban, & Bangalore rural, Chikkabalapura & Ramanagar) the specifications for the equipment will be as approved by IDSP, New Delhi. The World Bank / DGS&D Rate contract of Govt. of India procurement guidelines will be followed.

Hence a provision of **Rs. 115.00 lakhs** is proposed during Fy 2008-09.

5.1.B.5. Laboratory Equipment

Similarly there is need to supply Bio-Safety Cabin, Hot Air Oven, autoclaves, Digital electronic Balance, Incubators, Centrifuges etc, to the balance 23 Districts hence 25.00 lakhs proposed.

Hence a provision of **Rs. 25.00 lakhs** is proposed during Fy 2008-09.

5.1.B.6. IEC activities

IDSP Karnataka proposes to enhance IEC activities for creating awareness on the diseases covered under IDSP component through Press / Electronic media, Posters to Public Health Institutions, Panchayath Raj Institutions to display in predominant places etc. will be supplied. Laminated boards will be displayed indicating the tests done at the DSU laboratories.

Hence a provision of **Rs. 30.00lakhs** is proposed during Fy 2008-09.

5.1.B.7. Appointments of Microbiologist

At present out of sanctioned 26 posts only 10 are working. It was initially planned to out source 16 Microbiologists (MSc Medical Microbiology) against existing vacant post on contract basis. However proposal has been sent to Govt of Karnataka for permanent recruitment through KPSC/ DRC. If hired on Contractual basis, it is proposed to pay an Honorarium of Rs 15,000 per month per candidate.

Hence a provision of **Rs. 28.00 lakhs** is proposed during Fy 2008-09.

5.1.B.8. Supply of Office equipments & Air conditioners

There is need to supply office furniture's, Fax Machines, Air Conditioners, Display boards, Xerox machines, etc to those DSUs of the office of the Project Director IDSP & SSU for whom these items have not been supplied earlier either by IDSP or Directorate of Health &FW Services. The World Bank / DGS&D Rate contract of Govt. of India procurement guidelines will be followed.

Hence a provision of **Rs. 40.00** proposed during Fy 2008-09.

5.1.B.9. Mobile connections

To facilitates Speedy transfer of information and enhance communicability with all the DSU. It is proposed to provide Mobile phone facility to the Project Director IDSP, Deputy Director SSU, Zonal Deputy Directors of NAMP, and District Surveillance Officers, which will also cover recurrent expenditure.

Hence a provision of **Rs. 08.00 pr**oposed during Fy 2008-09.

5.1.B.10. Laptop

The office of the Joint Director Communicable Diseases and the Public Health Institute are actively involved with IDSP activities. They will be constantly reviewing & orientating the staff in IDSP components. Hence it is proposed to procure two laptop with accessories under DGS & D rate contract of Government of India to the office of Joint Director (CMD) & Joint Director Public Health Institute.

Hence a provision of **Rs. 01.25 lakhs** is proposed during Fy: 2008-09.

5.1.B.11. Training for newly recruited Medical officers & Paramedical staff

There is need to train newly recruited regular / contract / Ayush Medical Officers and some of the Laboratory Technicians who have not been trained in IDSP objectives. The training will be conducted at the respective District Training Centers, which are under the control of DH & FW Officers

Hence a provision of **Rs. 20.00 lakhs** is proposed during Fy 2008-09.

5.1.B.12. Printing of Manuals

There is need to train newly recruited regular / contract / Ayush medical officers in IDSP objectives. There is need to print and supply Medical Officers & laboratory manuals and Bio safety guidelines. The manuals will be made available to the trainees during the training program.

Hence a provision of **Rs. 10.00 lakhs** is proposed during Fy 2008-09.

5.1.B.13. NCD Activities:

Non Communicable Disease Survey has been taken up in Shimoga district on pilot basis. For the pilot study IDSP Govt. of India has provided funds. The findings emerging from the survey need to be disseminated throughout the state.

Hence a provision of **Rs. 04.00 lakhs** is proposed during Fy 2008-09.

5.1.C Budget:

Hence approximately budget estimate of Rs. 406.75 lakhs is proposed during Fy 2008-09 for IDSP Component under NRHM.

DETAILS BUDGET PRAPOSAL UNDER NRHM-IDSP COMPONENT FOR THE YEAR 2008-09.

SL. No	Subject	Amount Rs. In lakhs
1	Repairs and Renovations of State Surveillance unit, District Surveillance Unit/ District Laboratory etc.	40.00
2	Laboratory consumables & reagents	43.5
3	Operational Cost: Printing of forms and registers	42.00

SL. No	Subject	Amount Rs. In lakhs
4	Elisa Reader and Washer	115.00
5	Laboratory Equipment	25.00
6	IEC activities	30.00
7	Appointments of Microbiologist	28.00
8	Supply of Office equipments & Air conditioners	40.00
9	Mobile connections	08.00
10	Laptop	1.25
11	Training for newly recruited Medical officers & Paramedical staff	20.00
12	Printing of Manuals	10.00
13	NCD Activities	4.00
	TOTAL	406.75

5.1.D. ADDITIONAL INPUTS FROM NRHM FOR IDSP IN KARNATAKA

1. Sensitization of Private Practitioners (10 Workshops)

At present private hospitals and practitioners are not involve in the disease surveillance, it is proposed to conduct 10 workshops in the cities where more number of private hospitals and private doctors are working. The expenditure for each workshop will be Rs. 1 Lakh each, so total expenditure will be Rs. 10 Lakhs.

2. Pilot project on involvement of community/PRI in disease surveillance in 9 districts in 5 poor performing districts it is proposed to involve the community members like elected representatives, ASHAs and NGOs to report the diseases. The expenditure for each district will be Rs. 5 Lakh for 9 district total expenditure will be Rs. 45 Lakh.

3. Strengthening of Avian Influenza preparedness

- Training
- Logistics
  - Stocking of PPEs
  - Chemoprophylaxis
- Training of RRTs

There is already threat Avian Influenza, we have to get prepared to combat the disease to strengthen the preparedness on Avian Influenza the doctors and other staff to be trained the health workers has to be provided Personal Protection Equipments (PPE), tablet Tamiflu is not available in the market as chemoprophylaxis tamiflu has to be given to the high risk population. The rapid response team of Avian Influenza to be trained the total cost will be Rs. 50.00 Lakh

4. Augmenting the state and district RRTs response capacity

There are RRTs in the state and also in all the 29 districts, the RRT has to be strengthen b giving training, mobility support for 29 districts and for state total cost will be Rs. 34.00 Lakhs

The total cost required for IDSP as additional inputs from NRHM is Rs. 139.00 Lakhs.

Additional Input from NRHM to IDSP for the financial year 2008-09.

SL. No	Subject	Amount Rs. In lakhs
1	Sensitization of Private Practitioners (10 Workshops)	10.00
2	Pilot project on involvement of community	45.00
3	Strengthening of Avian Influenza preparedness	50.00
4	Augmenting the state and district RRTs response capacity	34.00
TOTAL		139.00

GOI approved for Rs.135.00 lakhs under IDSP and Rs.139.00 lakhs under NRHM additionalities

5.2 NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

The National Vector Borne Disease Control Programme is an umbrella which includes the Programmes for prevention and control of Vector Borne Diseases viz., Malaria, Filaria, JE, Dengue/DHF, Chikungunya & Kala-Azar. The Programme is implemented as per the National Policy of Government of India, Directorate of NVBDCP, Delhi.

This Programme is being implemented since December 2003, in Karnataka.

5.2.1 National Health Policy and Goals under National Rural Health Mission:

Towards reduction of Vector Borne Disease burden, the National Health Policy 2002 envisaged a goal of reducing mortality by 50% by 2010 and efficient morbidity control. Reduction of Malaria Morbidity and Mortality is also included in the Millennium development Goals to meet the overall objectives of reducing poverty. Reduction in Mortality on account of Dengue and Japanese Encephalitis by 50% and Elimination of Lymphatic Filariasis by 2015 are also the declared goals under the National Health Policy.

The NRHM - launched by the Hon'ble Prime Minister of India, in April 2005, refers to strengthening of Public Health System for efficient service delivery, particularly at village level and primary levels, equitable access to quality Health Care, reduction of Communicable Diseases and promotion of healthy behaviour as well as enabling Community ownership and creating demand for quality services.

5.2.A. MALARIA:

Malaria – a mosquito borne disease – continues to pose a serious Public Health problem in the State.

Main Objectives of the programme are:

1. to prevent deaths due to malaria,
2. to bring down the malaria morbidity to the lowest level,
3. to maintain the gains achieved,
4. To encourage community participation in malaria control.

5.2.A.1. The major regulatory functions/strategies under the programme are:

1. Early Detection and Prompt Treatment (EDPT):

a) Surveillance and Case detection,

b) Examination and Treatment

c) Functioning of Fever Treatment Depots, Drug Distribution Centres and Malaria Clinics

2. INTEGRATED VECTOR MANAGEMENT (IVM):

a) Indoor Residual Insecticide Spray Operation,

b) Biological methods of Vector Control using larvivorus fish

c) Use of Insecticide Treated Bed Nets

d) Environmental management & Minor Engineering methods for source reduction

3. ENTOMOLOGICAL SURVEILLANCE

a) Vector Prevalence

b) Bionomics of Vector Species

c) Resistance Status to conventional Insecticides

4. EPIDEMIC PREPAREDNESS AND RAPID RESPONSE:

a) Formation of District Epidemiological Control Team

b) Provision of a Vehicle for mobility

c) Intensification of Surveillance and Treatment activities

d) Establishment of Field Laboratory

e) Emergency Vector Control measures

5. INFORMATION, EDUCATION AND COMMUNICATION ACTIVITIES (IEC)

a) Health Education activities through Mass Media , Electronic Media, Print Media

b) Inter-Sectoral Co-ordination

c) Behavioural Change Communication and Social Mobilization

d) Inclusion of Health related sectors, Private NGOs – Private Public Partnerships

6. CAPACITY BUILDING:

a) Training activities for different Medical and Para-medical categories.

7. MONITORING AND EVALUATION:

a) Management information using Web-based system.

5.2.A.2. URBAN MALARIA SCHEME:

The scheme is implemented in 8 cities/towns of the State viz., Bangalore, Bellary, Hospet, Belgaum, Raichur, Hassan, Chikmagalur and Tumkur through the concerned local bodies. The objective of the programme is to control Malaria in Urban areas and is in vogue since 1972.

The main activities under the scheme are:

1. Anti-mosquito measures – i.e. anti larval operations by weekly application of larvicides.
2. Source reduction measures – to prevent the breeding of mosquitoes
3. Adulticidal measures – with Pyrethrum space spray in and around houses where Malaria cases are detected
4. Detection and Treatment activities are also taken up in Urban Slums.

5.2.B. FILARIA:

Filaria control activities are implemented in the districts of Gulbarga, Bagalkot, Bidar, Raichur, D. Kannada, U. Kannada and Udupi. At present there are 25 Filaria Clinics, 8 Filaria Control Units and 1 Survey Unit – functioning in these districts.

The Main activities under the Programme are:

1. Anti mosquito measures – i.e. weekly anti larval measures carried out through Filaria Control Units
2. Detection and Treatment of Micro-filaria and Disease cases through Filaria Clinics and Control Units through night blood surveys

3. Survey Unit at Raichur is to Conduct Filaria Surveys and Map out the problem of Filariasis in the district.

5.2.B.2. Mass Drug Administration (MDA):

With an objective to Eliminate Lymphatic Filariasis, the Government of India under NVBDCP, has taken up the Programme since 2004 with 100% Cash Assistance. The Programme is implemented in 8 endemic districts of Gulbarga, Bagalkot, Bidar, Raichur, Bijapura, D Kannada, U Kannada and Udupi. DEC is being administered on a Single day to the Eligible population (above 2 Yrs of age). The Programme is proposed for 5 to 7 years consecutively in order to eliminate Lymphatic Filariasis in the State.

Apart from MDA, management of Lymphoedema cases and Operations to Hydrocele cases is also being taken up in these districts under the Programme.

5.2.C. JAPANESE ENCEPHALITIS

Japanese Encephalitis is a Mosquito borne Viral disease regularly occurring in the districts of Bellary, Raichur, Kolar and Koppal. It is also reported to some extend from other neighbouring districts. The disease usually occurs during the post monsoon period and continues up to January. Children below 15 yrs are usually affected severely and the mortality rate among children is very high (up to 30%).

The activities under the programme are:

1. Epidemiological Surveillance, Diagnosis, Treatment and Management of all suspected JE cases.
2. Segregation of Pigs – 3 kms away from human habitation
3. Mosquito control measures, Out door fogging operations
4. Intensive Health Education and Personal Protection measures.

5.2.D. JE VACCINATION PROGRAMME:

Vaccination programme was introduced in the state against JE, during 2006. Bellary district was the district to take up the programme for immunizing children between 1-15 yrs during July 2006. During 2007 Japanese Encephalitis vaccination programme was done in the districts of Kolar and Raichur. Koppal and Mandya will be taken up for vaccination during 2008. The programme is sponsored by Government of India.

5.2.E. DENGUE/DHF and CHIKUNGUNYA

Dengue fever is a mosquito borne viral disease. The epidemic occurs during the pre and post monsoon periods. The vector mosquito viz., "Aedes aegypti" usually breeds in domestic and Peri-domestic water collections such as Cement tanks, drums, old tyres, tins, coconut-shells, air coolers, and so on. The diagnosis is by serological methods and the treatment is symptomatic.

Source reduction methods, Larvicides, Adulticides and fogging operations as well as IEC activities are some of the important control activities adopted.

The disease is prone in Bangalore City, Bangalore (Urban), Bangalore (Rural), Mandya, Kolar, Dakshina Kannada, Tumkur and Mysore districts. However, depending on the water storage practices, migration of population, the disease has also reported in other districts of the State.

Chikungunya is also a viral disease spread from the same Dengue vector mosquito. However, the disease is not fatal. The control activities are similar to that of Dengue/DHF disease.

5.2.F. PROPOSALS FOR INCLUSION OF COMPONENTS UNDER NRHM-NVBDCP FOR 2008-09 – TO BE ALLOCATED UNDER NRHM – FLEXI POOL

5.2.F.1. Malaria:

Human Resources (State Level)

1.	Technical consultant	Rs. 2.4 lakhs
2.	Accountant	Rs. 1.40 lakhs
3.	Driver	Rs. 1.20 lakhs
	Total =	**Rs. 5.00 lakhs**

5.2.G. Budget:

Revised Abstract of Components under NVBDCP/NRHM PIP for 2008-09 - KARNATAKA STATE			
Sl. No.	**Component/Sub-component**	**Cash Assistance proposed**	**State Share proposed**
1	***Malaria***		
1.1	EDPT	8.80	77.10
	IRS		71.25
1.3	ITN	11.50	
1.4	Bilogical control	21.45	
1.5	UMS	36.13	100.00
1.6	Entomological monitoring(Dist & Zonal level)	10.72	
1.7	Trg & Capacity bldg.	43.60	
1.8	Operational research	23.50	
Total for Malaria Component		**155.70**	**248.35**
2	***Filaria***		
2.1	State & Dist. Level mtgs	1.30	
2.2	Training of staff	6.40	
2.3	Hyd. Operations & Morbidity Management	4.83	
2.4	Drug Dist. Trg, Hon & Sup. Hon.	45.00	
2.5	IEC	17.96	
2.6	POL/Mobility	6.40	
2.7	Night Blood Survey	3.76	
2.8	MDA assessment	0.72	
2.9	Units/Clinics exp.		18.80
Total for Filaria Component		**86.37**	**18.80**

3	***Dengue/CHK***		
3.1	Sentinel Surveillance Centres/Hospitals	6.00	
3.2	Training of Staff	11.78	
3.3	Aedes surveillance, Entomological component (Pvt Public Partnership)	23.00	
Total for Dengue/Chikungunya Component		**40.78**	
4	***Japanese Encephalitis***		
4.1	Vector Control (fogging machines)	25.00	
4.2	Training of staff	3.95	
Total for JE Component		**28.95**	
5	***Quality Assurance***		
5.1	Printing of Manuals	3.00	
5.2	Quality monitoring	1.55	
5.3	Orientation workshops	2.90	
Total for QA component		**7.45**	
6	***I.E.C.***		
6.1	Malaria	35.10	
6.2	Dengue/CHK	25.80	
6.3	J.E.	15.10	
Total for IEC component		**76.00**	
Total Assistance proposed for 08-09		***395.25***	***267.15***

Diseases wise IEC activities proposed for 2008-09					
Sl No	**Particulars of activity**	**Level of Activity**	**Qty**	**Unit cost (Rs)**	**Total cost (in lakhs)**
Malaria					
1	**Anti Malaria Month Activities**				
	State level activities		1	30000	0.30
	District level activities		29	20000	5.80
	Taluk level activities		176	5000	8.80
	Problematic PHC activities		70	1000	0.70
2	**Other IEC activities during Peak seasons**				
3	TV spot production (Advt)		1	200000	2.00
4	TV advertisements		LS		5.00
5	Print media advertisements		LS		5.00
6	Advocacy sessions	Panchayat level	500	1500	7.50
Total for Malaria component					**35.10**
Dengue/Chikungunya					
1	Hoardings	Districts	29	20000	5.80
		Cities	10	30000	3.00
2	TV spot production (Advt)		1	200000	2.00
3	TV Advertisements		LS		5.00
4	Print media advertisements		LS		10.00
5	Advocacy sessions	Panchayat level	100	2000	2.00
Total for Dengue Component					**25.80**
J.E					
1	Handouts on JE prevention		10	11000	1.10
2	Posters		10	20000	2.00
3	TV Advertisements		10	LS	5.00
4	Print media			LS	7.00
Total for JE component					**15.10**
Total for all Diseases under IEC					**76.00**

2008-09 Annual Plan for Commodity Assistance (Central and State Shares) - KARNATAKA STATE

Sl No	Component	Particulars of logistic support	Technical requirement	Balance on hand during 2007-08	Practical requirement 08-09	Unit rate (Rs.)	Total Cost estimates (in lakhs)			Total Cash assistance (State + Centre) for logistic support (Rs)
							Central Share		State Share	
MALARIA							Cash assistance	Commodity Assistance		
1.1	1. EDPT Materials	*Blood Lancets*	*9000000*	*0*	*9000000*	*0.6*			*54.00*	*54.00*
1.2		*Microglass slides*	*2500000*	*0*	*2500000*	*0.7*			*17.50*	*17.50*
1.3		*Cotton roll*	*8000*	*0*	*8000*	*30*			*2.40*	*2.40*
1.4		*Antiseptic lotion (100 ml)*	*8000*	*0*	*8000*	*15*			*1.20*	*1.20*
1.5		*Slide boxes (25 slides)*	*8000*	*0*	*8000*	*25*			*2.00*	*2.00*
1.9		Rapid Diagnostic Kits	11000	0	11000	80	8.80			8.80
	SUB TOTAL						8.80		*77.10*	85.90
2.1	**2. Drugs/ Anti Malarials**	Combi Bilster packs (Chloroquine + Primaquine)	600000	437250	162750					0
2.2		Chloroquine tablets	40000000	2300000	37700000					
2.3		Primaquine tablets (2.5mg + 7.5mg)	5000000	4200000	800000					
2.4		ACT blister packs (adutls)	35000	0	35000					
2.5		Quinine injections	1000	0	1000					
2.6		Arteether injections	1800	0	1800					
2.7		Sulfadoxine/Pyremethamine tabs	50000	0	50000					

Sl No	Component	Particulars of logistic support	Technical requirement	Balance on hand during 2007-08	Practical requirement 08-09	Unit rate (Rs.)	Total Cost estimates (in lakhs)			Total Cash assistance (State + Centre) for logistic support (Rs)
							Central Share		State Share	
							Cash assistance	Commodity Assistance		
MALARIA										
2.8		Quinine Sulfate tablets	30000	0	30000					
	SUB TOTAL									
3.1	**3. Vector Control & Personal Protection**	DDT 50% wdp (in MT)	85	10	75					
3.2		***Malathion 25% wdp (in MT)***	***100***	***0***	***100***	***50000***			***50.00***	***50.00***
3.3		Synthetic Pyrethroid wp (in terms of 2.5%) - in MT	48	35	13					
3.4		***Stirrup pumps***	***1000***	***150***	***850***	***2500***			***21.25***	***21.25***
3.5		Bednets	240000	120000	120000					
3.6		Synthetic Pyrethroid flow (lts)	3600	0	3600					
	SUB TOTAL								***71.25***	***71.25***
4.1	**4. Anti larval measures (UMS/NFCP)**	Pirimiphos Methyl (lts)	2000	0	2000					
4.3		Temephos (lts)	6000	2225	3775					
4.4		Pyrethrum Extract 2%	11000	600	10400					
4.5		Bti (larvicide)	900	0	900					
	Grant-in-aid	***Grant-in-aid bills of local bodies (8 UMS towns)***		***1***					***100.00***	***100.00***
4.6	**SUB TOTAL**						**0**		***100.00***	**100.00**
Total for Malaria component							**8.80**		***248.35***	**257.15**

Sl No	Component	Particulars of logistic support	Technical requirement	Balance on hand during 2007-08	Practical requirement 08-09	Unit rate (Rs.)	Total Cost estimates (in lakhs)			Total Cash assistance (State + Centre) for logistic support (Rs)
							Central Share		State Share	
							Cash assistance	Commodity Assistance		
MALARIA										
FILARIA										
5.1	**5. ELF (Filaria)**	DEC tablets	36000000	5000000	31000000					
		State share for commodities							***18.80***	***18.80***
JAPANESE ENCEPHALITIS										
6.1	**6. Outdoor fogging**	Technical Malathion (in MT)	**2**	**1**	**1**					
		SUB TOTAL								
GRAND TOTAL FOR LOGISTIC SUPPORT 08-09							**8.80**		***267.15***	***275.95***

Note: Bold Italics Fonts represents STATE Share components

GOI approved for Rs.440.00 lakhs cash assistance and Rs.402.00 lakhs commodity assistance under NVBDCP and Rs.5.00 lakhs under NRHM additionalities.

5.3. NATIONAL LEPROSY ERADICATION PROGRAMME

5.3.1. Introduction

Leprosy is a public health problem and also a social problem in the State. National Leprosy Elimination Programme (NLEP) was conceived as a Control Programme and was launched in 1954-55. Its main thrust was early detection, sustained and regular treatment of all patients with 'Dapsone'. This had some limitations like, treatment was long leading to irregular treatment and development of drug resistance.

After inception of Multi-Drug Treatment (MDT)in Karnataka, the prevalence rate per 10,000 population has been brought down to 0.61 at the end of December 2007 from 50 in 1986. Remarkable achievement was also made in prevention of deformity, i.e. the deformity rate has been brought down to 0.87 of the new cases detected. As on today, the goal of elimination i.e., prevalence rate of less than 1 per 10,000 population has been achieved in 24 districts (Chitradurga, Shimoga, Tumkur, Chikmagalur, Dakshina Kannada, Hassan, Kodagu, Bangalore (U), Bangalore ®, Belgaum, Davangere, Bagalkot, Haveri, Gulbarga, Uttar Kannada, Gadag, Bidar, Udupi, Mandya, Raichur, Bijapur, Dharwad, Kolar, & Mysore) and 3 district have prevalence rate of between 1.12 to 2.05 (i.e., Bellary, Koppal and Chamarajnagar) The state is considered as a low endemic state. During 2007-08 (up to December 2007) 3555 new cases were detected and 3118 cases have been arrested/cured. Leprosy eradication programme is implemented in the state, through 29 District Leprosy Societies and 25 NGOs under the supervision of a Joint Director (Leprosy) stationed in Bangalore.

5.3.2. PHYSICAL TARGET AND ACHIEVEMENTS FROM 1999-2007

(UP TO DEC-2007)

New Cases Detected				Cases Cured			PR	Deformity Rate
Year	Target	Ach	%	Target	Ach	%		
99-2000	10000	23095	230.95	14000	21154	151.10	3.10	1.07
2000-01	8000	17882	223.52	14000	19986	142.75	2.18	1.02
2001-02	8000	21307	266.34	14000	19584	139.84	2.45	0.79
2002-03	13890	13070	94.09	19720	15340	78.00	1.90	1.00
2003-04	-	10598	-	-	12522	-	1.40	0.79
2004-05	-	6133	-	-	7486	-	1.08	0.40
2005-06	-	5307	-	-	6611	-	0.57	0.45
2006-07	-	4299	-	-	4455	-	0.50	1.23
2007-08 up to Dec-07	-	3555	-	-	3188	-	0.61	0.87

State is well towards the elimination goal.

5.3.3. Budget Allocation and Expenditures From 1999-2007 (Up to Dec.2007)

	Govt. of India Cash Assistance 100% CSS (Plan)			State Plan	
Year	**Budget Allocation (in lakhs)**	**Actual Release from Govt. of India**	**Expn (in lakhs)**	**Budget Allocation (in lakhs)**	**Expn (in lakhs)**
99-2000	71.00	64.54	44.71	70.66	113.51
2000-01	62.00	55.18	8.50	105.07	125.55
2001-02	62.00	30.00	28.74	155.09	133.32
2002-03	50.00	30.00	14.18	50.00	39.54
2003-04	50.00	22.17	15.11	50.07	41.35
2004-05	50.00	12.50	12.50	42.15	33.70
2005-06	63.25 (ZP)	14.00	14.00	3.50	-
2006-07	56.25	14.29	13.35	-	-
2007-08	-	-	-	-	-

5.3.4. Main Objectives:

1. Early detection through self reporting and treatment completion through intensified IEC activities.
2. Prevention of deformities by early detection and prompt treatment.
3. Disseminate correct information about the disease and removing, misconception by means of Health Education for the Community, Family and Individual.
4. Delivery of quality services to Leprosy Affected Persons (LAP).
5. Further reduction in prevalence rate.
6. Providing rehabilitation services to cured leprosy patients.

5.3.5. Plan of Action for 2008-09.

1. Intensified Health Education Activities with special campaigns in the districts with PR of more than1/10,000 population. .
2. Disability prevention and medical rehabilitation of patients of below poverty level.
3. Training for all the Health Personnel including Private practitioners.
4. Rehabilitation services provided to cured leprosy patients in all the districts.
5. To Achieve the elimination of PR <1/10000 in all the districts by the end of March 2009.

To achieve the above objectives following action plan/budget is proposed. In the proposed plan, no funds are provided for training as funds allotted in previous years are still available with State Institute of Health and Family Welfare for utilization. No provision is made for Urban leprosy programme also as ULC has all ready been completed. More emphasis is proposed for IEC activities especially in districts where PR is more than the state average.

An amount of Rs.1.11 lakh is provided for in the action plan for automation of office operation in the State Headquarters as the existing computer, fax machine and Xerox machine have become very old and are beyond repair. For smooth function of the office, replacement of the existing equipment are a must.

The proposed action plan is submitted for approval please.

5.3.6. Budget

Sl. No.	Activities and approved PIP norms of expenditure	Amount Proposed (Rs.in Lakhs)
I	**Contractual Services**	
	1. Epidemiologist @ Rs. 22,000/- p.m.	2.64
	2. BFO @ Rs. 14,300/- x 12 months	1.72
	3. A.O. @ Rs. 12,100/- p.m.	0
	4. Steno @ Rs. 7150/- p.m.	0
	5. Clerk @ Rs. 7150/- p.m.	0
	6. DEO @ Rs. 7150/- p.m. x 12 months	0.86
	7. Drivers @ Rs. 3850/- p.m. x 12 months x 8 nos	3.7
	8. TA/DA to Drivers	0.75
	9. Honararium @ Rs. 400 p.m. / dist. for accounts work x 29x 12 months	1.4
	10. Audit fee State + Districts	1.36
	Total	**9.79**
II	**Office Expenditure**	
	1. SLS @Rs. 30,000/- year for Telelphone, Fax, Computer, Xerox etc.	0.3
	2. DLS @ 15,000/ yr. for Telephone etc. x 29 district	4.35
	3. Broad band connection at State Society and district society (Rs.1200x12x30)+ One time installation charges (Rs.3000x30)	5.22
	Total	**9.87**
III	**Consumables**	
	1. SLS @ 20,000/- year for Stationary	0.2
	2. DLS @ 10,000/ yr. per district for Stationery x 29 districts	2.9
	Total	**3.1**
IV	**Vehicle and Hiring**	
	1. SLS @ 60,000 / year x 2	1.2
	2. DLS @ 50,000 / year x 29 dist. X2	29
	Total	**30.2**

Sl. No.	Activities and approved PIP norms of expenditure	Amount Proposed (Rs.in Lakhs)
V	**Supportive Medicines**	
	1. DLS @ 20,000/- year x 29	**5.8**
	Total	**5.8**
VI	**Materials and Supplies**	
	1. Splints and Crutches @ 4000/- yr. / dist. X 29 dist.	1.16
	2. MCR foot wear @ 230 x 60 pairs / dist. X 29 dist.	4
	3. Patient welfare @ 7000/ yr. / dist. X 29 dist. Blankets	2.03
	4. Printing cost @ Rs. 9200/- yr. Dist. X 29 dist.	2.67
	Total	**9.86**
VII	**IEC**	
	IEC activities as per IEC norms	
	1. Hoardings cost per unit Rs. 15,000 x 5x6 district.	4.5
	2. Quiz (cost per unit is Rs. 3000 x 58)	1.74
	3. Folk show 325 shows x Rs. 3000	9.75
	4. IPC Workshops (health workers & MOs) cost per unit Rs. 10,000 x 29 dist.	2.9
	5. Orientation camps for NGOs and Mahila mandals Cost per unit camp is Rs. 2300 x 29 dist.	0.67
	6. Health melas cost per unit Rs. 3450 x 29 dist.	1
	7. Wall painting	8.5
	8. IPC workshops for influential / opinion leaders.Cost per camp unit is Rs. 575 x 1800	10.35
	9. Observation of Anti Leprosy month Rs.10,000 dist x 29 dist	2.9
	10. Observation of Anti Leprosy month State Leprosy Society Rs. 20000	0.2
	11. IEC Special Action plan for Districts having PR of more than 1 per (Bellary, Koppal & Chamarajanagar)	15
	Total	**57.51**
VIII	**Review Meetings, Workshops & Trainings**	
	1. State level meeting @ Rs. 25,000/- per meeting x 4 meetings	18.40 (Rs.1 lakh for meetings & 17.40 for training)
	Total	**18.40**

Sl. No.	Activities and approved PIP norms of expenditure	Amount Proposed (Rs.in Lakhs)
IX	**Disability prevention and Medical Rehabilitation (DPMR)**	
	120 RCS Patients of BPL category in 29 district.(Rs. 5,000 x 120)	6
	M.R. Medical College (Rs 5000 x 60)	3
	Total	**9**
X	**SET Scheme**	
	1. Amount for NGOs under SET Scheme	4.5
	Total	**4.5**
XI	**Automation of State Society office &District Society Offices**	
	a) Purchase of computer, fax machine, and Xerox machine and one Laptop Rs. 30000x32+16000+65000+50000)	10.91
	Total	**10.91**
	Grand Total	**158.33**

GOI approved for Rs. 190.38 lakhs

NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS IN KARNATAKA STATE

5.4.1. PREAMBLE :

Blindness is a major public Health problem of our country with an estimated 12.00 million (120.00 lakhs) blind persons. To tackle this problem National Programme for Control of Blindness was launched with the aim to reduce prevalence rate of blindness from 1.4 to 0.3% by the turn of 2012.

Encouraging Eye Ball Collection for Keratoplasty among the blind so as to give them vision is one of the important activity of National Programme for Control of Blindness.

Cataract is the dominant cause for Blindness accounting for nearly 2/3rd of the Blind population. Timely intervention through cataract operations restores Eye Sight for the cataract affected patients. Through Grant-in-Aid to NGO Sector they are encouraged to perform free cataract operations for the patients irrespective of social or economic status.

5.4.2. Objective :

The Programme aims at reduction in the incidence of the blindness from 1.78% to 0.3% by 2012 A.D. The main cause of blindness are cataract which covers 69%, Refractive Errors –19.7%, Corneal Blindness-0.9%, Glaucoma-5.8%, Surgical Complications-1.2%, Posterior Segment Disorders –4.7% and others-5.0%. The population of Karnataka is 5.20crores. The incidence rate in Karnataka is 1.29%. The estimated prevalence is above 4.8 lakhs. To tackle this aspect following infrastructure was developed.

5.4.3. STATE OPHTHALMIC CELL

One State Ophthalmic cell has been created to plan, monitor and to evaluate the programme with the following staff.

Joint Director(Ophthalmology)

Assistant Statistical Officer

Stenographer Grade-1

Second Division Assistant

Driver

Group ' D'

5.4.4. KARNATAKA STATE BLINDNESS CONTROL SOCIETY :

To implement the National Programme for Control of Blindness effectively , strengthening monitoring of District Blindness control Societies and release of Grant-in Aid to the Districts. The Karnataka State Blindness Control Society (KSBCS)was registered on 08-08-2002. The KSBCS has since been merged with State Health and Family Welfare Society under NRHM. The Principal Secretary to Government Health and FW Department is the Chairman of the Society with Joint Director (Ophthalmology) as the Member Secretary.

5.4.5. DISTRICT BLINDNESS CONTROL SOCIETIES (DBCS) :

The DBCS functions at the district level as per the guidance of the KSBCS .The National Blindness Control Programmes are implemented and coordinated at the district level as many NGOs are actively involved in implementing various activities. District Blindness Control Societies have been established in all the 29 districts. The DBCS functions with the Deputy Commissioner/Chief Executive Officer of Zilla Parishad as the

Chairman and the District Leprosy Officer and incharge District Programme Manager as the Member Secretary. The following are the functions of DBCS.

a) Periodically assess the magnitude of the problems of blindness in the District & to monitor and to report

b) To motivate voluntary organizations in arranging Eye Camps, providing free spectacles to the poor patients who under goes cataract surgery and school children identified with Refractive Error under School Eye Screening Programme

c) Grant in Aid to voluntary organization for free eye camps

d) Maintenance of Village Blind Register

e) Maintenance of proper accounts and furnishing UCs and SOE to KSBCS from time to time.

5.4.6. MINTO REGIONAL INSTITUTE OF OPHTHALMOLOGY

Minto Ophthalmic Hospital, Bangalore has been upgraded as Regional Institute of Ophthalmology with state of the art ophthalmic equipments under NPCB to provide Advanced Eye Health Care and to provide IOL training for Eye Surgeons Reorientation training for Para medical Ophthalmic Assistants, Staff Nurses under NPCB programme.

5.4.7. UPGRADATION OF MEDICAL COLLEGES

Five medical colleges have been upgraded to provide higher clinical ophthalmic services. Qualified Super specialists are working in these institutions. They are

a. JJM Medical college, Davanagere

b. J,N.Med.college, Belgaum

c. KMC Hubli

d. Medical college, Mysore &

e. Medical college, Bellary

5.4.8. UPGRADATION OF DISTRICT HOSPITAL

All district hospitals of Karnataka have been developed to provide surgical/clinical ophthalmic services with the following staff

Ophthalmic Eye surgeons

Paramedical Ophthalmic Assistants

These District Hospitals have been provided with a separate Operation Theatre and provided with an Operating Microscope and other costly equipments. So that, they can do regular catops and other eye operating can be conducted even daily.

5.4.9. UPGRADATION OF GENERAL HOSPITAL

7 General Hospitals in the State have been upgraded to provide Clinical and surgical Ophthalmic Services to Rural Communities by the following staff.

Ophthalmic Surgeon

Paramedical Ophthalmic Assistants

5.4.10. UPGRADATION OF DISTRICT MOBILE OPHTHALMIC UNITS

31 District Mobile Ophthalmic units are functioning in the State to Provide creative,promotive and surgical facilities to rural and tribal communities by adopting camp approach with the following staff:

Ophthalmic Eye surgeons

Block Health Educator

Staff Nurse

Paramedical Oph. Assistants

Driver

Group 'D'

For arranging rural camps, NGO's are actively participated in the programme.

5.4.11. UPGRADATION OF PRIMARY HEALTH CENTRES:

426 PHC's were developed with a creation of one Ophthalmic assistants. Post to give primary eye health care facilities to rural community.

5.4.12. EYE BANK & EYE DONATIONS CENTRES

Three eye banks are functioning at Minto Hospital, Bangalore: K.R. Hospital, Mysore and District hospital, Belgaum to provide grafting services with super specialists. About 3 Eye Banks are working in Non Government Sector, and 2 Eye Donation Centres are working. Govt of India had also introduced the scheme to encourage the voluntary organizations for establishing / development of eye banks and Eye Donation Centres. All voluntary organizations have been informed through district blindness control societies to utilize the opportunity to serve people.

5.4.13 IOL TRAINING

Under National Programme for Control of Blindness , IOL insertion training is given in Minto Hospital, Bangalore. Duration of the training is 2 months. Two Eye surgeons are deputing for each batch. Till date, 105 eye surgeons have been trained for IOL and 22 eye surgeons are trained for Small Incision Cataract Surgery. NPCB orientation training has been given to 192 Staff nurses and 226 Para Medical Ophthalmic Assistants.

5.4.14.SCHOOL EYE SCREENING PROGRAMME :

Screening of School children for refractive errors is the important activity of the National Programme for Control of Blindness. Every year, middle school children are primarily screened by the trained teachers and then by Para Medical Ophthalmic Assistants, and poor students who have refractive errors, will be distributed free spectacles by District blindness Control Society.

13. PHYSICAL TARGET & ACHIEVEMENTS UNDER N.P.C.B.

Year	Target	Achievement	%
2002-03	2,20,000	2,44,680	111%
2003-04	2,20,000	2,63,613	119%
2004-05	2,50,000	2,66,931	107%
2005-06	2,50,000	2,86,427	115%
2006-07	2,50,000	2,98,555	119.42 %
2007-08	3,50,000	2,26,107 (up to Dec'07)	65.00%

5.4.15 ALLOCATION OF FUNDS & EXPENDITURE OF STATE PLAN & C.S.S SCHEME:

(Rs.in lakhs)

State Plan			Central Plan		
Year	Released	Expenditure	Year	released	Expenditure
2002-03	60.00	59.93	2002-03	23.00	27.63
2003-04	0.10	0.10	2003-04	20.00	23.23
2004-05	0.50	0.50	2004-05	84.00	73.44
2005-06	50.00	47.83	2005-06	84.00	44.87
2006-07	3.00	3.00	2006-07	80.00	53.37
2007-08	1.00	0.10 (Up to Dec'07)	2007-08	50.00	8.35 (Up to Dec'07)

5.4.13. Grant in Aid released to Karnataka State Blindness Control Society from Govt. of India:

(Rs. in lakhs)

Year	Released	Expenditure
2002-2003	214.85	118.34
2003-2004	399.65	250.58
2004-2005	411.75	527.75
2005-2006	176.00	131.00
2006-2007	641.08	561.04
2007-2008	684.50 (651.50 – Up to Dec'07)	390.03 (Up to Dec 2007)

5.4.17. Budget Requirement

Sl. No.	Programme/Activity	Budget per UNIT in Lakhs	No. of UNITS Proposed	Amount (Rs.in lakhs)
	Grant-in-Aid - (New Schemes under NPCB)			
	a. Non-recurring Grant-in-Aid:			
1	Extension of Eye care unit in - NGO sector in the underserved Area/Tribal Areas @ Rs. 25 lakhs	25.00	4	**100.00**
2	Eye Bank - Development of Eye Banks in NGO Sector @ Rs.10 lakhs	10.00	5	**50.00**
3	Eye Donation Centre - Development of Eye Donation Centre in NGO Sector @ Rs.1 lakh	1.00	5	**5.00**
4	Vision Centre - Strengthening of Vision centre in NGO Sector under NPCB @ Rs.25,000/-	0.25	50	**12.50**

5	Commodity assistance for Medical Colleges for Ophthalmic equipments for strengthening Ophthalmology department @ Rs. 30 lakhs-(Any of the **two New Govt. Medical Colleges)**	30.00	2	**60.00**
6	Commodity assistance for District Hospitals for Ophthalmic equipments for strengthening Ophthalmology department @ Rs. 12 lakhs	12.00	5	**60.00**
7	Commodity assistance for Taluk Hospitals for Ophthalmic equipments for strengthening Ophthalmology department @ Rs. 3 lakhs	3.00	5	**15.00**
	b. Recurring Grant-in-Aid			
8	Spectacles for School Children & Post Operative Patients @ Rs.125/- per child/ patient	0.00125	20,000	**25.00**
9	Cataract Surgery @ Rs.750/- per cataract operations-Grant-in-Aid to DBCS	0.00750	275,000	**2062.50**
10	School Eye Screening @ Rs.1 lakh each dist approximate			**30.00**
11	Eye Ball Collection @ Rs.1,000 per pair of Eye Balls	0.01	5000	**50.00**
12	**IEC activity:**			
	Printing and supply of Hoardings, Pamphlets, Calendars, Advertisements, TV /Cable , Newspapers			**10.00**
13	**Training activity**			
	Training of PHC MOs, Staff Nurses, PMOAs			**5.00**
14	Staff Remuneration, TA,DA, OE, Contingencies, & other activities			**10.00**
	TOTAL			**2495.00**

Total budget: Rs. 2495 lakhs

GOI approved for Rs.1038.00 lakhs

5.5. National Iodine Deficiency Disorders Control Programme:

5.5.1. Introduction:

NIDDCP is a 100% centrally sponsored scheme. This programme is implemented in order to prevent iodine deficiency disorders. The deficiency of iodine leads to mental retardation, stunted growth, and deafmutism lowering of IQ, Goitre, a visible manifestation, frequent abortions. The use of Non Iodised salt is banned in all the districts of the state. Educational activities are conducted to create awareness about IDD and to motivate the public to use only iodised salt.

The IDD week is celebrated from 21st October to 27th October every year. The salt samples are collected by food Inspectors under PFA act and samples are sent to PHI for analysis to know the quality of Iodised salt. Similarly the field functionaries also collect salt samples, which are also sent to PHI for analysis.

5.5.2. The progress for the year 2007-08 is as follows:-

April to Nov.07

The No. of Goitre cases	Salt –Samples Collected			
	Under PFA		Non PFA	
	Satisfactory	Non-Satisfactory	Satisfactory	Non-Satisfactory
545	16	02	99	76

5.5.3. Budget Provision for 2007-08.

During 2007-08 an amount of Rs.17.29 Lakh is earmarked by Govt. of Karnataka, out of which Rs. 17.00 Lakh for salary component & Rs.0.29 lakh for non salary component. The expenditure of salary component is Rs. 2,54,542 up to Nov. 2007. Govt. of India has allocated an amount of Rs.13.00 Lakh Grant and released 6.12 lakh up to Sept.07.

5.5.4. Budget for 2008-09.

Particulars	**Amount (in Lakhs)**
1. Establishment of IDD Control cell	6.00
2. Establishment of IDD Monitoring lab	3.5
3. IEC materials	12
4. IDD surveys	2.5
Total	**24.00**

GOI approved for Rs.24.00 lakhs under NIDDP and Rs.160.00 lakhs under NRHM additionalities

5.6. NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF DEAFNESS – KARNATAKA

(NRHM)

5.6.1. Introduction:

Hearing loss is the most common sensory deficit in humans today. As per WHO estimates in India, there are approximately 63 million people, who are suffering from significant auditory impairment; this places the estimated prevalence at 6.3% in Indian population. As per NSSO survey, currently there are 291 persons per one lakh population who are suffering from severe to profound hearing loss (NSSO, 2001). Of these, a large percentage is children between the ages of 0 to 14 years. With such a large number of hearing impaired young Indians, it amounts to a severe loss of productivity, both physical and economic. An even larger percentage of our population suffers from milder degrees of hearing loss and unilateral (one sided) hearing loss.

5.6.2. OBJECTIVES OF THE PROGRAMME

1. To **prevent** the avoidable hearing loss on account of disease or injury.

2. Early identification, diagnosis and treatment of ear problems responsible for hearing loss and deafness.

3. To **medically rehabilitate** persons of all age groups, suffering with deafness.

4. To **strengthen the existing inter-sectoral linkages** for continuity of the rehabilitation programme, for persons with deafness.

5. To **develop institutional capacity** for ear care services by providing **support for equipment and material and training personnel**.

Long term objective: To prevent and control major causes of hearing impairment and deafness, so as to reduce the total disease burden by 25% of the existing burden by the end of eleventh five year plan.

5.6.3. STRATEGIES

- To strengthen the service delivery including rehabilitation.
- To develop human resource for ear care.
- To promote outreach activities and public awareness through appropriate and effective IEC strategies with special emphasis on prevention of deafness.
- To develop institutional capacity of the district hospitals, community health centers and primary health centers, selected under the project.

A pilot project, to be conducted in 25 districts derived from 10 states and 1 union territory, is already in the first phase of implementation. This will run from 2006 to 2008. In the remaining four years of the 11th Five year plan, it is proposed to expand this programme to include a total of 203 districts covering all the states and Union territories of India by 2012. The expansion will be done in a phased manner, with inclusion of 45 new districts each year. At the end of the plan, it is proposed to cover 50% of the districts in all the pilot states (except Uttar Pradesh) and 25% of the districts in all the other states/UTs.

5.6.4. EXPECTED BENEFITS OF THE PROGRAMME

The programme is expected to generate the following benefits in the short as well as in the long run.

i. Large scale direct benefit of various services like prevention, early identification, treatment, referral, rehabilitation etc. for hearing impairment and deafness as the primary health center / community health centers / district hospitals largely cater to their need.

ii. Decrease in the magnitude of hearing impaired persons.

iii. Decrease in the severity/ extent of ear morbidity or hearing impairment in large number of cases.

iv. Improved service network for the persons with ear morbidity/hearing impairment in the states and districts covered under the project.

v. Awareness creation among the health workers/grassroot level workers through the primary health centre medical officers and district officers which will percolate to the lowest level as the lower level health workers function within the community.

vi. Larger community participation to prevent hearing loss through panchyati raj institutions, mahila mandals, village bodies and also creation of a collective responsibility framework in the broad spectrum of the society.

vii. Leadership building in the primary health centre medical officers to help create better sensitization in the grassroots level which will ultimately ensure better implementation of the programme.

viii. Capacity building at the district hospitals to ensure better care.

ix. State of the art department of ENT at the medical colleges in the state/union territory under the project.

5.6.5. Karnataka state was one of the states chosen for pilot phase of the NPPCD, 2006-8. The three districts of Mandya, Hassan & Dharwar(Hubli) were the pilot phase districts.

The Districts of Kolar, Chamarajanagar, Udupi Uttara Kannada and Gadag are the districts chosen for the expansion phase of NPPCD for the year 2008-9 .

NPPCD-- KARNATAKA 2008-9									
	Kolar, Chamarajanagar, Udupi Uttara Kannada and Gadag								
1	CAPACITY BUILDING			District hospitals					
	ENT Operating Microscope					Rs.9.50 lakhs each		Rs47.50 lakhs	
	Microdrill					X 5 nos			
	Microsurgery instruments								
	Audiometry room								
	Digital Audiometer								
	OAE analyser								
	Impedance audiometer								

2	CAPACITY BUILDING			PHC`s & CHC`s		Rs 10000 each		Rs.37.20 lakhs	
				372 kits@ Rs 10000			37,20.000		
	Headlight								
	Ear specula								
	Ear syringe								
	Otoscope								
	Jobson Horne probe								
	Tuning Forks								
	Noise maker								
3	Training :			Through SIHFW, Bangalore & DTC					
	ENT surgeons/ audiologists	NO /batch	No of days of trg	No of batches	Cost / batch	Total		Rs. 35.32 lakhs	
	Obstetricians & paediatricians	25	3	1	45700	45700			
	PHC/CHC Doctors	25	1	5	20000	100000			
	SN / HWM / ANM	25	2	13	5700	74100			
	AWW/Asha	25	1	330	6600	2178000			
	School teachers	60	4 hrs	250	4325	1081250			
		50	5 hrs	100	5375	53750			
4	Screening camps		10/dist					Rs. 5.00 lakshs	
			@ Rs10,000 /camp						
				Total :					

5.6.6. Budget for NPPCD under NRHM additionalties

4.	State Program Office:					3532800			
	State Nodal Officer : 1		Nil						
	Asst Program Officers : 2		2x15000/month						
	Computer/Office Asst : 1		6000/month						
	Office exp like telephone, internet, etc		2500/month						
	Sub Total		38500X 12			Rs. 500000		Rs. 5.00lakhs	
2	Microsurgery training for ENT surgeons							Rs. 3.00 lakhs	
3	Surgical consumables							Rs. 2.00 lakhs	
4	Mobility support for state programme team							Rs. 1.00 lakhs	
	Total							**Rs. 11.00 lakhs**	

Grand total for NPPCD= Rs.125.00 lakhs + Rs.11.00 lakhs = Rs.136.00 lakhs

GOI approved for Rs.135.00 lakhs and Rs.11.00 lakhs under NRHM additionalities

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5.7. Revised National Tuberculosis Control Programme:

5.7.1 Revised National Tuberculosis Control Programme, Karnataka State

5.7.2 Goal:

To decrease mortality and morbidity due to TB and cut transmission of infection until TB ceases to be a major public health problem.

5.7.3 Objectives:

1. To achieve and maintain a cure rate of at least 85% among newly detected infectious (new sputum smear positive) cases, and
2. To achieve and maintain detection of at least 70% of such cases in the population

5.7.4 Targets for 2007-09:

1. To attain Cure Rate of at least 80% and 75% respectively among New Smear Positive and Smear Positive re-treatment cases. Also, to achieve Conversion rate of at least 90% among NSP cases.
2. To reduce the default rate to less than 5% and 15% respectively among NSP and Smear Positive re-treatment cases. To reduce death rate to less than 5% among both new smear positive and new smear negative cases.
3. To attain and maintain case NSP case detection rate of more than 70%.
4. Establishment of Drug sensitivity testing laboratory (Inter-mediate Reference Laboratory).

5.7.5 Strategy:

1. Pursue high quality DOTS

- Implementation of all components of DOTS

2. Address TB/HIV, MDR-TB and other challenges like prisoners, refugees and other high risk groups and special situations

- Strengthen the implementation of TB/HIV collaborative activities
- Prevent and control multi-drug resistance TB

3. Contribute to health system strengthening
4. Engage all care providers

- Public-public and public private mix approaches

5. Empower people with TB, and communities

- Advocacy, communication and social mobilization

6. Programme based operational research

- Encourage Medical Colleges to undertake operational research and provide funds for research from RNTCP, as per guidelines. Widely publicize among Medical Colleges regarding the financial assistance available under RNTCP to under take operational research

5.7.6 Activities planned / proposed in Karnataka State during 2008-09, to achieve and maintain the objectives of RNTCP:

5.7.7 1. To improve case detection activities in the state:

- Monthly review of referral of chest symptomatics at all Peripheral Healt Institutions, with special emphasis on District and Taluk Hospitals. Doctor-specifi review will be carried out in major hospitals.
- Reduce initial defaulters by taking correct address and contact details of th patients and strengthening the feedback for cases referred for treatment out-sid the TU but within the district.
- Separate review of poor performing districts at divisional and state level
- Strengthening involvement of Medical Colleges / NGOs / Private Health Sector in RNTCP
- Training activities under RNTCP and TB/HIV will be taken up on priority.
- Sensitization of Medical Officers regarding importance of following the diagnostic algorithms recommended by RNTCP, both for pulmonary and extra-pulmonary TB suspects.
- DMCs which are non - functional / partially functional due to unavailability of LTs trained in RNTCP will be made functional.

5.7.8 *2. Strengthening case holding activities by reducing default rates:*

- Initial home visits by the health workers, before starting treatment
- Strengthening DOT and default retrieval activities
- Ensuring follow-up sputum examinations for all TB patients on DOTS, as per guidelines
- Operationalization of GO regarding conversion of TB hospitals in the state to General Hospitals / Care and Support Centre for PLHA / Training Centres
- Further strengthening of feedback mechanism for transferred cases – inter-district and border districts inter-state meetings
- Adequate decentralization of DOT and involvement of more umber of community volunteers / PPs as DP
- Initiation / timely payment of honorarium to community DOT Provider
- Regular review of supervision by field staff supervision by District officers
- Appointment of adequate numbers of TB Health Visitors for Urban areas, as per guidelines
- Training and involvement ASHAs and Link Workers for DOT
- Intense review of Districts and TB Units with poor conversion and cure rate.
- Regular conduct of patient – provider meetings in all the districts.
- Facilities like seating arrangements and drinking water facilities will be provided at all DOT Centres, utilizing un-tied funds under NRHM.

5.7.9 3. Reducing high death rate among TB patients on DOTS:

- Conduct of death audit for TB patients who died during treatment under RNTCP
- Early diagnosed and timely initiation of treatment.

- Improving TB/HIV coordination activities in the state. All TB patients are offered HIV counseling and testing. HIV infected patients would be given CPT and ART, as per guidelines. Where ever necessary such patients would be referred to Care and Support Centres for further management.
- Correct categorization of patients to ensure that previously treated TB patients are given Cat II regimen.

5.7.10 4. Strengthening IEC activities:

- Extensive use of Mass media line TV, radio and news papers for creation of awareness regarding TB and availability of DOTS services, there by increasing the demand for services.
- Increasing the number of Community meeting and Patient – Provider meetings conducted in the districts.
- Better utilization of Communication Facilitators provided under RNTCP.
- RNTCP IEC Officer to tour the districts and provide necessary technical inputs on IEC activities, both at district and state level
- More emphasis will be given to carry out effective Advocacy, Communication and Social Mobilization (ACSM) activities in poor performing districts.

5.7.11 5. Improvement in Financial Issues:

- It will be ensured that quarterly Statement of Expenditures, Audit Reports and Utilization Certificates are submitted well within the time frame.
- Action will be initiated for replacement of 2-wheelers provided to STS/STLS, which are older than 6 years and are not fit.
- State Accountant(s) will make supervisory visits all the districts ensure better financial management at the district level, as recommended in the RNTCP financial manual of RNTPC PIP-II.
- Adequate and timely utilization of funds under all the financial heads of RNTCP will be ensured.

5.7.12. Annual Plan for Programme Performance & Budget

Objectives:
1. To achieve and maintain a cure rate of at least 85% among newly detected infectious (new sputum smear positive) cases, and
2. To achieve and maintain detection of at least 70% of such cases in the population

This action plan and budget have been approved by Satate Health & Family Welfare Society - TB Division

Section-A – General Information about the State

1	State Population (in lakh) *please give projected population for next year*	**574 lakhs**
2	Number of districts in the State	**29 + 1 (BMP)**

3	Urban population	**18996512**
4	Tribal population	**891769**
5	Hilly population	**1927525**
6	Any other known groups of special population for specific interventions (e.g. nomadic, migrant, industrial workers, urban slums, etc.)	**4453624**

(These population statistics obtained from District action plan)

No. of districts without DTC: Nil

No. of districts that submitted annual action plans, which have been consolidated in this state plan: **29+1**

Organization of services in the state:

Sl. No.	Name of the District	Projected Population (in Lakhs)	Please indicate number of TUs of each type		Please indicate no. of DMCs of each type in the district		
			Govt	NGO	Public Sector*	NGO	Private Sector^
01	Bagalkot	**17.98**	4	-	18	-	1
02	Bangalore City	**45.41**	9	-	37	6	7
03	Bangalore Rural	**9.00**	2	-	10	-	1
04	Bangalore Urban	**25.59**	5	-	24	-	2
05	Belgaum	**45.79**	9	-	41	1	1
06	Bellary	**22.04**	4	-	23	-	-
07	Bidar	**16.34**	3	-	17	-	1
08	Bijapur	**19.69**	4	-	19	-	2
09	Chamarajanagara	**10.50**	3	-	12	3	-
10	Chickmagalur	**12.40**	4	-	19	-	-
11	Chikka Ballapur*	**12.35**	3		13	-	-
12	Chitradurga	**16.44**	3	-	15	-	1
13	Dakshina Kannada	**20.64**	5	-	23	-	6
14	Davanagere	**19.48**	4	-	21	-	2
15	Dharwad	**17.46**	4	-	19	-	2
16	Gadag	**10.58**	2	-	11	-	-
17	Gulbarga	**34.01**	7	-	35	1	2
18	Hassan	**18.74**	4	-	17	-	-
19	Haveri	**15.65**	3	-	14	-	-
20	Kodagu	**5.94**	3	-	10	1	-
21	Kolar	**15.12**	3	-	15	-	1
22	Koppal	**12.99**	3	-	13	-	-
23	Mandya	**19.18**	4	-	22	-	1

Sl. No.	Name of the District	Projected Population (in Lakhs)	Please indicate number of TUs of each type		Please indicate no. of DMCs of each type in the district		
			Govt	NGO	Public Sector*	NGO	Private Sector^
24	Mysore	**28.57**	6	-	27	1	1
25	Raichur	**17.94**	4	-	17	-	2
26	Ramanagara*	**11.43**	2	-	12	-	-
27	Shimoga	**17.85**	4	-	19	-	1
28	Tumkur	**28.08**	5	1	26	1	1
29	Udupi	**12.08**	3	-	17	-	1
30	Uttara Kannada	**14.73**	4	-	17	-	-
	Total	**573.99**	**123**	**1**	**583**	**14**	**36**

***New districts* Chikka Ballapur from Kolar district and Ramanagara from Bangalore rural district programme implementing from 2008.**

5.7.13. RNTCP performance indicators: *Important: Please give the performance for the last 4 quarters i.e.* ***Oct 2006 to September 2007***

Name of the District (also indicate if it is notified hilly or tribal district	Total number of patients put on treatment*	Annualised total case detection rate (per lakh pop.)	No of new smear positive cases put on treatment *	Annualised New smear positive case detection rate (per lakh pop)	Cure rate for cases detected in the last 4 correspondin g quarters	Plan for the next year	
						Annualised NSP case detection rate	Cure rate
Bagalkot	1863	104	742	41	73	45	80
Bangalore City	6945	153	2092	46	64	54	75
Bangalore Rural*	2279	113	879	43	84	48	85
Bangalore Urban	3393	133	1206	47	75	54	85
Belgaum	4330	96	1617	36	72	68	85
Bellary	3348	152	1466	67	71	73	84
Bidar	1523	95	582	36	72	60	85
Bijapur	2258	115	719	37	56	60	70
Chamarajana gara	15050	147	583	57	80	61	85
Chickma galur	1159	93	427	34	85	54	87
Chitradurga	2225	135	1033	63	80	75	85
Dakshina Kannada	2106	102	861	42	76	55	85
Davanagere	2497	128	924	47	78	70	85

Name of the District (also indicate if it is notified hilly or tribal district	Total number of patients put on treatment*	Annualised total case detection rate (per lakh pop.)	No of new smear positive cases put on treatment *	Annualised New smear positive case detection rate (per lakh pop)	Cure rate for cases detected in the last 4 correspondin g quarters	Plan for the next year	
Dharwad	2019	116	722	41	78	75	85
Gadag	975	93	242	23	71	75	85
Gulbarga	3519	105	1310	39	72	70	85
Hassan	1733	92	774	41	85	50	90
Haveri	1687	108	633	40	75	50	80
Kodagu	434	73	189	32	90	40	90
Kolar*	3353	122	1460	53	84	60	90
Koppal	1729	133	841	65	77	75	88
Mandya	2658	139	1135	59	82	90	90
Mysore	3747	131	1394	49	81	55	85
Raichur	2985	166	1337	75	81	80	86
Shimoga	1262	71	700	39	86	60	85
Tumkur	3054	109	1333	47	81	53	85
Udupi	1185	98	481	40	86	65	90
Uttara Kannada	1118	76	381	26	57	75	85
Total	**64335**	**116**	**25949**	**47**	**77**	**63**	**85**

- *Patients put on treatment under DOTS regimens only are to be included.*

* *Ramanagaram (Bangalore Rural) & Chickaballapur (Kolar) new districts not applicable.*

5.7.14. Section B – List Priority areas at the State level for achieving the objectives planned:

Sl. No.	Priority areas	Activity planned under each priority area
1	Case detection activities	1) Monthly review of case detection at district / taluk Hospitals. 2) Sensitization of DHOs/ DS. & training all Medical Officers under RNTCP. 3) Sensitization of Medical College Staff & Private Practitioners 4) Intensive supervision & Monitoring by district level/ State level 5) Providing Medical officers to Medical colleges for better co ordination of RNTCP work. 6) Relocating poorly performing DMC's to a place which is likely to show performance. 7) Establishing new DMCs

Sl. No.	Priority areas	Activity planned under each priority area
2	Case holding Activities	1) Training and utilisation of ASHA workers as DOT providers 2) Strengthening referral system & transfer mechanism by inter district and inter state coordination & border meeting 3) Sensitization of field staff. 4) Decentralization of DOT Centre. 5) Involving more number of Aganvadi teachers as DOT providers 6) Prompt payment of Honorarium to Anganwadi workers & community DOT providers.
3	IEC activities	1. Strengthening IEC activities by use of mass media communications. 2. Making the best use of communication facilitators at district level.
4	TB HIV Co-ordination	1. Better co-ordination between ART & DTC . 2. Involvement of district supervisor's oppointed by KSAPS. 3. Sensitisation of counsellors of ICTCs regarding RNTCP. 4. Strengtheninig RNTCP in AWAHAN linkages. 5. Intensive supervision and monitoring of all ICTCs. 6. Involvement of NGOs working under KSAPS. 7. Displaying IEC materials in all ICTC's.
5	MEDICAL COLLEGES	1. Regular STF meetings. 2. Operating DOT centers in all Medical Colleges. 3. Providing Lab.technicians and TB HVs to all Medical Colleges and Medical Officers to leading Medical Colleges. 4. Regular core committee meetings. 5. Sencitization and Training of faculties/ internies and students. 6. Fecilatate operational research in Medical Colleges. 7. Support CMEs, seminars under RNTCP in Medical Colleges. 8. Intensive supervision by STF Chairman and STO to Medical Colleges.

Sl. No.	Priority areas	Activity planned under each priority area
6	CLOSING OF TB SANATORIUMS	1. Steps will be taken to closing and converting the TB sanatoriums. 2. Implimentation of Government Order under process.
7.	Providing sputum culture and sensitivity facilities to TB patients.	Culture and sencitivity lab – civil works is under progress.

5.7.15. Priority Districts for Supervision and Monitoring by State during the next year

Sl. No	*District*	*Reason for inclusion in priority list*
1	*Bagalkot*	*Low performance in case detection, convertion rate, curerate, Initial defaulter rate, deth rate And in HIV incidence*
2	*B M P*	
3	*Bidar*	
4	*Bijapur*	
5	*Dharwad*	
6	*Gadag*	
7	*Gulbarga*	
8	*Uttara Kannada*	
	Bangalore Rural	
	Bangalore Urban	
	Shimoga	

5.7.16. Annual Plan 2008-09

Section C – Consolidated Plan for Performance and Expenditure under each head, including estimates submitted by all districts, and the requirements at the State Level

1. Civil Works

Activity	*No. required as per the norms in the state*	*No. already upgraded/ present in the state*	*No. planned to be upgraded during next financial year*	*Pl provide justification if an increase is planned in excess of norms (use separate sheet if required)*	*Estimated Expenditure on the activity*	*Quarter in which the planned activity expected to be completed*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*
STDC/ IRL	*1*	-	*1*	-	*1010000*	-
SDS	*1*	-	-	-	-	-
DTCs	*30*	*28*	*2*	-	*9,26,000*	-
TUs	*124*	*122*	*2*	*7*	*2,28,600/-*	-
DMCs	*633*	*629*	*4*	*5*	*749000*	-
				TOTAL	**29 13,600**	

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2. Laboratory Materials

Activity	*Amount permissible as per the norms in the state*	*Amount actually spent in the last 4 quarters*	*Procurement planned during the current financial year (in Rupees)*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ Remarks for (d)*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
Purchase of Lab Materials by Districts	*7766109*	*5541844*	*5663670*	*8550000*	
Lab materials for EQA activity at STDC	*840000*	*24000*	*840000*	*855000*	
Total				**94,05,000**	

3) Honorarium

Activity	*Amount permissible as per the norms in the state*	*Amount actually spent in the last 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ Remarks for (d)*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
Honorarium	*40,25,000*	*594370*	*1599325*	*5000000*	*40% of the treatment completed cases that is twenty thousand cases will be covered by community volunteers in order to bring down defaulters rates*
		No. presently involved in RNTCP		*Additional enrolment proposed for the next fin. Year*	
*Community volunteers in all the districts**		*3498*		*16502*	

government and are involved in provision of DOT e.g. Anganwadi workers, trained dais, village health guides, ASHA, other volunteers, etc.

5.7.17. IEC/PUBLICITY: STO OFFICE / KARNATAKA

Permissible budget for state and all Districts as per Norms: Rs.**64, 36,730/-**

Estimated IEC budget for all Districts, as per action plans (Please enclose consolidation summary): **Rs.48, 36,730/-**

Estimated IEC activities and budget at the state level (excluding districts) Rs. **10, 00,000/-**

+ Communication Facilitators salary including state annual action Rs 6, 00,000/-

Total Amount for STO Office Karnataka Rs. 16, 00,000/-

5.7.18. For the next financial year As per action plan detailed below: -

Target Group/ Objective	Activities Planned at State Level						Total Activities proposed During Next Fin. Year	Estimated Cost per activity Unit	Total Expenditure For the Activity During the Next in. Year
	Activity (All activities to be planned as per local needs, catering to the target groups specified)	No. Of activities Held in last 4 Quarters Both state & District	No of activities proposed in The next financial year, quarter wise						
			Apr-Jun	July-Sep	Oct-Dec	Jan-Mar			
Patients and General public / for awareness generation and social mobilization	Outdoors:								
	- Wall paintings	**381**	-	-	-	-	-	-	-
	- Hoardings	**231**	-	-	-	-	**05**	**20,000 /-**	**1,00, 000/-**
	- Tin plates	**05**	**05**	-	-	-	-	-	-
	- Banners/ Anti TB week	**693**	-	-	-	-	-	-	-
	- Others	**300**	-	-	-	-	-	-	-
	Outreach activities:								
	- Patient provider interaction meetings	**1672**	-	-	-	-	-	-	-
	- Community meetings	**690**	-	-	-	-	-	-	-
	- Mike publicity	**46**	-	-	-	-	**20 Auto's**	**750/-**	**15.000/-**
	10 auto Per day Rs.750/- For two days								
	- Others	**10**	-	-	-	-	-	-	-
	Puppet shows/ **Street plays**/etc.	**37**	**05**	**04**	**05**	**04**	**18**	**2500/-**	**45,000./-**
	School activities	**192**	-	-	-	-	-	-	-

	Print publicity								
	- Posters	**3520**	-	-	-	-	-	-	-
	- Pamphlets	**84500**	-	**1,00,000**	-	-	**1,00,000/**	**0.80**	**80,000/-**
	- Others	**800**	-	-	-	-	-	-	-
	- Sticker	-	-	-	-	**10.000**	**10.000**	**3.00**	**30.000/-**
	- Cinema Slides	-	-	-	-	-	-	-	-
	-TV. Spots	-	-		-	-	-	-	-
	Media activities on Cable/ **Local channels Radio, (Only kannada radios)** Period of one Month, Private Local Radio Channel	**11**	All India Radio FM Rainbow	(FM 91)	(Big 92.7 FM radio,	FM 93.4 FM Private Channel	Every quarter one radio pro gramme, For four months	For one Program, Per prgm cost 50,000/ .	**2,00,000/-**
	Any other activity/ TV. Ads in E TV. Kannada & Udaya TV. Kannada for the period of one month (selected popular kannada serials in the prime time OR news time) Majority of the people to concentrate on the local channels	-	One month ETV, weekly thrice, 10 Seconds Rs 13,000/-	-	One month Udaya TV, weekly Thrice, 10 seconds Rs 13.000/-		Total 24 days Rs 10,000x 24 Days Excluding Bounce points extra	10,000/-	**2.40,000/-**
	Sensitization meetings	**188**	**01**	**01**	**01**	**01**	**04**	**10,000/-**	**40,000/-**

Opinion leaders/ NGOs for advocacy	Media activities	**03**	**01**	**01**	**01**	**01**	**04**	**10,000/-**	**40,000/-**
	Power point Presentations / one to one interaction	**41**	**01**	**01**	**01**	**01**	**04**	**10,000/-**	**40,000/-**
	World TB Day activities	**92**	-	-	-	1,00,000/-	**01**	**1,00,000/-**	**1,00,000/-**
	Any other public event	**28**	-	-	-	-	-	-	-
Health Care providers – public and private	- CMEs -Interaction meetings - One to one interaction meetings	**13** **202**	**01** - -	**01** - -	**01** - -	- - -	**03** - -	**10,000/-** - -	**30,000/-** - -
	Information Booklets Any other {Health mela& others	**110** **28** **02**	-	- -	- -	- -	-	-	-
Any Other Activities proposed	Communication Facilitators (each for 5-6 districts) total 05 CF, **Each district 20,000/- (Excluding TA/DA.)**	**Total 30 District**	-	-	-	-	-	-	**Total 30 District's 6, 00,000/-**
Ads on State circulation news paper in State level	For the occasion of W TB day & other days.	-	**01**	**01**	**01**	**01**	**04**	**10, 000/-**	**40,000/-**
Total Activities	Conducted last 4Quarters Both state, districts, IEC Officer & CF Activities							**Total Budget**	**Rs. 16,00,000/-**

- CF (one CF visited in a month 5-6 districts) In action plan including CF Salary in the state annual action plan,

Rs. 6,00,000/-According to the RNTCP Guidelines for hiring of CF 20,000/- per year. Total 05 CF

5. Equipment Maintenance:

Item	*No. actually present in the state*	*Amount actually spent in the last 4 quarters*	*Amount Proposed for Maintenance during current financial yr.*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ Remarks for (d)*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
Computer (maintenance includes AMC, software and hardware upgrades, Printer Cartridges and Internet expenses)	30	395773	670500	840000	
Photocopier (includes AMC, toner etc.)	30	168460	345000		
Fax	8	25500	11500		
OHP	2	300	57000		
Binocular Microscopes	662	993000	550200	9,93,000	
STDC/ IRL Equipment	-	-	-	-	
Any other (pl. specify)	-	-	-	-	
			TOTAL	**1833000**	

7.Vehicle Maintenance:

Type of Vehicle	*Number permissible as per the norms in the state*	*Number actually present*	*Amount spent on POL and Maintenance in the previous 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ remarks*
	(a)	(b)	(c)	(d)	(e)	(f)
Four Wheelers	17	17	2068230	1961940	1975000	-
Two Wheelers	126	118	1934923	2571980	31,00,000	-
				TOTAL	**5075000**	

6. Training

Activity	No. in the state	No. already trained in RNTCP	No. planned to be trained in RNTCP during each quarter of the next FY				Expenditure (in Rs.) planned for current FY	Estimated expenditure for the next FY for which plan is being submitted	Justification / remarks
			Q1	Q2	Q3	Q4			
	(a)	(b)	(c)				(d)	(e)	(f)
Training of Mos	4168	3818	330	332	166	62	1095218	1954780	
Training of LTs of DMCs Govt + Non Govt	521	487	57	32	19	2	151500	253780	
Training of MPWs	10933	9421	637	633	508	498	911925	1214602	
Training MOTC			25			25		224000	
Training STS				10		10	0	103200	
Training STLS			10		10	0	0	148500	
Training LT			30	30	30	30	0	438000	
Training of MPHS, pharmacists, nursing staff, BEO etc	5731	3746	598	488	336	248	761750	882085	
Training of Comm volunteers	5242	1987	688	836	835	936	179940	616050	
Training of Pvt Practitioners	3290	904	613	690	697	813	1106250	1423802	
Other trainigs		4	25	25	25	24	100000	110000	
Re-training of Mos	2643	1049	487	400	395	423	780301	62100	
Re-training of LTs of DMCs	359	56	83	69	83	59	166332	223580	
Re-training of MPWs	5078	1212	968	640	785	723	969442	1136602	
Re-training of MPHS, pharmacists, nursing staff, BEO etc	2871	180	510	737	573	450	428926	732225	
Re-training of Comm volunteers	2183		500				46100	28000	
Re-training of Pvt Practitioners.	837	30	150	150	100	120	127720	126230	
TB / HIV trainig of Mos	2064	1419	229	358	302	333	676300	936030	
TB/HIV Training of STLS, LTs, MPWs, MPHs, Nursing staff, Community Volunteers etc	8615	2022	2135	2150	1513	1232	1464280	1949870	
TB/HIV Training of STS	39	38	10			1	33850	9350	
Provision for Update Trainig at various levels								50000	Update training to use Pediatric PWB for all category of staff at Bangalore Urban dist.
Any other training activity	126	261	101	53	23	59	72000	57000	
							9071834	**12679786**	

8.Vehicle Hiring*:

Hiring of Four Wheeler	Number permissible as per the norms in the state	Number actually requiring hired vehicles	Amount spent in the prev. 4 qtrs	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)	(e)	(f)
For STC/ STDC	2	2	-	-	420000	-
For DTO	16	16	1194324	2226800	3360000	
For MO-TC	57	43	613182	1164070	2528400	
				TOTAL	**6308400**	to increase the involvement of MOTCs in supervision and monitoring.

* *Vehicle Hiring permissible only where RNTCP vehicles have not been provided.*

9. NGO/ PP Support:

Activity	No. of currently involved in RNTCP in the state	Additional enrolment planned for this year	Amount spent in the previous 4 quarters	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)	(e)	(f)
NGOs involvement scheme 1	13	34	131910	785000	403000	-
NGOs involvement scheme 2	4	24	132213	463000	747500	-
NGOs involvement scheme 3	1	11	-	290000	80000	-
NGOs involvement scheme 4	14	02	250000	350000	800000	-
NGOs involvement scheme 5	1		230500/-	340000	404000	-
Private practitioners scheme 1	365	4	5000/-	263100	149200	-
Private practitioners scheme 2	325	581	5000-	145000	135000	-
Private practitioners scheme 3A	0	0	-	0	0	-
Private practitioners scheme 3B	0	0	-	0	0	-
Private practitioners scheme 4A	0-	0	0	0	0	-
Private practitioners scheme 4B	0					
				TOTAL	**2718700**	

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10. Miscellaneous:

Activity* e.g. TA/DA, Stationary, etc	Amount permissible as per the norms	Amount spent in the previous 4 quarters	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year (Rs.)	Justification/ remarks
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
TA / DA/ Stationary etc	*9250000*	*4000706*	5752468	9250000	*At state level 7 Laks Distric leve1 8750000*
Transportation of DrugsFrom SDS	*300000*			300000	*Transportaion of Drugs*
			TOTAL	***9550000***	

- *Please mention the main activities proposed to be met out through this head*

11. Contractual Services:

Category of Staff	No. permissible as per the norms in the state	No. actually present in the state	No. Planned to be additionally hired during this year	Amount spent in the previous 4 quarters	Expenditure (in Rs) planned for current fin. year	Estimated Expenditure for the next financial year (Rs.)	Justification/ remarks
	(a)	*(b)*	*(c)*		*(d)*	*(e)*	
TB/HIV Co-ord.	-	-	-	-	-	-	
Urban TB Co-ord.	-	-	-	-	-	-	
MO-STCS	*1-*	*0-*	*1-*	-	-	*216000*	
State Acctt	*2*	2	*0*	*180000*	*189000*	396000	
State IEC Offr	*1-*	*1*	-	*189000*	*1,98,000/-*	*189000*	
Pharmacist	-	*0*	-	*0*	-	-	
Micro biologist	*1*	*1*		**192000**	*0*	201600	
Secretarial Asst	*1-*	*1*	-	*81000*	*84000*	*87000*	
MO-DTC	*8*	*8*	*2*	*570000*	*576000*	*582000*	
STS	*126*	*124*	*2*	*8117980*	*7964750*	*1,2276000*	
STLS	*126*	*124*	*2*	*7873119*	*7870100*	*1,2276000*	
TBHV	*150*	*106*	*44*	*5541194*	*10431200*	*11880000*	
DEO	*31*	*29*	*2*	*174737*	*2299100*	*2468400*	
Accountant – part time	*30*	*27*	*3*	*725034*	*632000*	*792000*	
Contractual LT	*126*	*108*	*18*	*5814027*	*7071750*	*10810800*	
Driver	*1*	*0*		*0*	*0*	*0*	
Any other contractual post approved under RNTCP	*0*	*0*	*0*	*0*	*0*	*0*	
					TOTAL	**52174800**	

12. Printing:

Activity	*Amount permissible as per the norms in the state*	*Amount spent in the previous 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
Printing-State level: MPW module, treatment cards, Lab register, Store register etc.	*840000*	*5,44,770/-*	*8,40,000*	*1400000*	-
Printing- Dist. Level: Training modules, annex. Forms etc	*6809565*	*1327050*	*4008427*	*70,00,000*	-
Total				*84,00,000*	

13. Research and Studies (excluding OR in Medical Colleges):

Any Operational Research projects planned (Yes/No) **No**

(If yes, enclose annexure providing details of the Topic of the Study, Investigators and Other details)

Whether submitted for approval/ already approved? (Yes/No) **No**

Estimated Total Budget _____

14. Medical Colleges

Activity	*Amount permissible as per norms*	*Estimated Expenditure for the next financial year (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*
Contractual Staff:			
▪ *MO-Medical College (Total approved in state 12)*	6528000	3840000	*Eight Medical officers will given for medical colleges*
▪ *STLS in Medical Colleges (Total no in state _--__)*	0	0	
▪ *LT for Medical College (Total no in state 32)*	2340000	3276000	Seven medical colleges will be given LTs
▪ *TBHV for Medical College (Total no in state___)*	2160000	*2808000*	All medical will be given TBHVs
Research and Studies:			
▪ Thesis of PG Students	*680000*	*410000*	*For 20 colleges*
▪ Operations Research*	5,00,000 (Per medical College)	2500000	for 5 studies

Activity	*Amount permissible as per norms*	*Estimated Expenditure for the next financial year (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*
Travel Expenses for attending STF/ZTF/NTF meetings	*131000*	*585000*	-
IEC: Meetings and CME planned	*170000*	*170000*	*for 34 medical cilleges.*
Equipment Maintenance at Nodal Centres	-	-	-
Total		**13589000**	

** Expenditure on OR can only be incurred after due approvals of STF/ STCS/ZTF/CTD (as applicable)*

15. Procurement of Vehicles:

Equipment	*No. actually present in the state*	*No. planned for procurement this year (only if permissible as per norms)*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*
4-wheeler **	0	0	0	-
2-wheeler	118	44	2200000	-
Total			**Rs 2200000**	

*** Only if authorized in writing by the Central TB Division*

16. Procurement of Equipment:

Equipment	*No. actually present in the state*	*No. planned for this year (only as per norms)*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*
Computer	*30*	*6*	*360000*	-
Photocopier	*28*	*2*	*200000*	-
OHP	*27*	*6*	*0*	-
Any Other	-	-	-	-
Total			**560000**	

Section D: Summary of proposed budget for the state

01. Civil works	2913600
02. Laboratory materials	9405000
03. Honorarium	5000000
04. IEC/ Publicity	6436730
05. Equipment maintenance	1833000
06. Training	12680000
07. Vehicle maintenance	5075000
08. Vehicle hiring	6308400

09. NGO/PP support	2718700
10. Miscellaneous	9550000
11. Contractual services	52174800
12. Printing	8400000
13. Research and studies	0
14. Medical Colleges	13589000
15. Procurement –vehicles	2200000
16. Procurement – equipment	560000
Total	138844230

5.7.19. Additionalties under NRHM flexi pool:

Programme management unit (including programme management specialist)

Total cost: Rs.10.00 lakhs

5.7.20.

IEC ACTION PLAN FOR THE YEAR 2008-09

Sl. No	Name of the District's	District's wise Population	2008	Permissible Budget as per Norms
	DISTRICT	DISTRICT CODE		
1	Bagalkot	BLK	1798395	134880
2	Bangalore City	BLC	4541403	681210
3	Bangalore Rural	BLR	2043499	68100
4	Bangalore Urban	BLU	2558766	383815
5	Belgaum	BEL	4579454	343500
6	Bellary	BLY	2204402	165330
7	Bidar	BDR	1634191	122564
8	Bijapur	BIJ	1968882	147800
9	Chamarajanagar	CRN	1049578	78718
10	Chikmagalur	CHK	1239873	93000
11	Chitradurga	CDG	1643827	123500
12	Dakshina Kannada	DKN	2064166	154812
13	Davanagere	DVG	1948016	145500
14	Dharwad	DHA	1745672	130700
15	Gadag	GDG	1057938	79600
16	Gulbarga	GBG	3401295	255097

Sl. No	Name of the District's	District's wise Population	2008	Permissible Budget as per Norms
	DISTRICT	DISTRICT CODE		
17	Hassan	HAS	1873593	140350
18	Haveri	HVR	1565058	117300
19	Kodagu	KOD	593563	44200
20	Kolar	KOL	2746636	108650
21	Koppal	KPP	1299077	97500
22	Mandya	MDY	1917566	143817
23	Mysore	MYS	2857120	214350
24	Raichur	RCR	1794019	134500
25	Shimoga	SHI	1784640	133840
26	Tumkur	TUM	2807710	210500
27	Udupi	UDU	1207644	90850
28	Uttara Kannada	UKN	1473017	110476
29	Ramanagaram	New districts	1133082	84981
30	Chikkabalapura	New districts	1297197	97290
	STO Office			1600000
	TOTAL		**57399000**	**6436730/-**

GOI approved for Rs.921.00 lakhs under RNTCP and Rs.11.00 lakhs under NRHM additionalities

Chapter - 6

Part – E

Inter-Sectoral Convergence

The inter sectoral convergence efforts in the state of Karnataka focuses on building operational level synergies along with common goals and shared work plans to achieve them; between associated sector departments like Women Development & Child Welfare, Rural Development, Department of Panchayati Raj, AYUSH and Education Department.

1. Village Health and Water Sanitation Committee

The village health and water sanitation committee provides an opportunity for grass root level convergence. The state has already issued notifications for the formation of Village Health and Sanitation Committees at all the villages at the site.

These committees are to expected to be fully operationalised in the next few months and will play key role in the decentralized planning process.

2. Integration of Health department and AYUSH

Focused efforts would be made by the state to ensure the integration of the Indian Systems of Medicine to the mainstream health delivery system. The following actions are being undertaken as a first step toward this process;

- 331 AYUSH doctors are being appointed at all single doctor PHCs in the state.
- Separate budgetary provision has been made under the the NRHM PIP for FY 06-07 for initial stocking of required AYUSH drugs in these PHCs.

3. Integration of Health & Rural Development

Nutrition along with sanitation is key health determinants in ensuring a healthy population. Also the rural development initiatives compliment the health function through the network of AWWs at the village level.

The department of health is in the process of evolving a joint convergence strategy with the rural development department to address the health related issues in a coordinated manner.

The following steps are being already being considered;

- Joint organization of village health days once a month in all villages.
- Sharing of data / joint survey format for household level surveys at all the villages across the state.
- Joint action and work plans at GP and Block level through the decentralized planning exercise.

4. Joint strategies with Women and Child Development and Education departments.

The following issues will be addressed to evolve a convergence strategy with the woman and child department.

1. Department should play more pro-active role in women development activities, rather than that on implementing certain activities.
2. It must coordinate with Health and family welfare department closely
3. It should impart training in gender and women empowerment among women groups

4. It should develop IEC material and distribute through its wide network
5. It should analyse the data of vital events collected by AWWs and disseminate it among local community routinely
6. It should approve projects for women empowerment
7. AWWs should motivate the community for 100 % registration of vital events (birth and death) with local registrar within 21 days i.e. Secretary Gram Panchayat

Education plays a key role in the improvement of overall health of the community. The following issues are expected to be addressed in evolving a convergence strategy among the departments.

1. Education department should promote positive values amongst children by undertaking various activities
2. It should willingly accept the responsibility entrusted to it for increasing awareness and behaviour change among students
3. Girl child must be given its due priority in the schools
4. There should be no discrimination against girls in the school
5. Due care must be given towards special need of girl students such as toilets in the school

Already the health and education department has opportunities of cooperation at the implementation of the various school health activities envisaged as a part of the RCH II programme.

6. Structure for Convergence

Development of a structure for convergence to address the project implementation goals and objectives and monitoring and review issues in key in ensuring the success of the convergence efforts.

The state plans to utilise the opportunity provided by the NRHM suggested structures like the Block Core Groups and District Core Groups for addressing the issue at the district and block level. The representation from allied sectors will be ensured in the district and block planning teams during the decentralised planning activity planned in FY 08 –09.

Chapter – 7

INNOVATIONS

7.1. Madilu

(Post natal care kit for BPL & SC/ST women in the state)

To reduce the MMR and IMR and to improve institutional deliveries, Government of Karnataka launched a New programme on Maternal Health called "MADILU" on1st October 2007.

The aim of the Madilu programme is to provide a Post-natal kit to the delivered mother which contains the components for mother and the new born baby like bedspreads, soaps and detergents etc. The beneficiaries for Madilu kits are BPL & SC/ST mothers who deliver in Government Institutions and are restricted to first two live births.

The total number of beneficiaries in Karnataka State is around 1 lakh per annum. For the year 2008-09, the budget required is Rs.10 crores.

Cost of each madilu Kit	–	Rs. 1000/-
No. of Beneficiaries	–	1 lakh
Total amount required	-	Rs. 1000.00 lakhs

Cost : Rs. 1000.00 lakhs from NRHM & 400.00 lakhs from State Govt

GOI approved for Rs.1000.00 lakhs

7.2 School Health Programme

Introduction:

The School Health Service is the Personal Health Service and is being implemented from many years, from narrower concept of medical examination of children to the present day concept of comprehensive care of Health and well being of children throughout the academic year.

Objectives:

The School Health Programme has been implemented in all the Primary , Higher Primary and High schools in both Rural and Urban areas of the State. All the District Health and F.W Officers are implementing the Programme effectively as per the instructions of this Directorate.

Now this Programme has been extended to the students of 8^{th} 9^{th} and 10^{th} standard students, for which Micro Plan of Action has been prepared and submitted to Government for approval. The following are the various activities.

1. Medical Examination of the students of 1^{st} , 4^{th} and 7^{th} Std. and 2^{nd} 3^{rd} 5^{th} and 6^{th} std. 8^{th} 9th and 10^{th} std .
2. Immunization of children with 1st booster dose of DT to 1st Std. Students & 1^{st} booster dose of TT to 4^{th} Std. Students and 2nd booster dose of TT to 10th Std. Students
3. Providing treatment for minor ailments.
4. Students requiring specialist care are referred to nearest hospital regularly.

5. Health Education to teachers as well as students regarding personal hygiene, environmental sanitation, safe drinking water and use of latrines are being taught regularly.
6. Teachers training on School Health are being conducted at Primary Health Centre level.
7. Medical kits are supplied to schools of Rural areas through Government Medical Stores.

This is the programme being implemented by two departments i.e., Department of Public Instruction and Department of Health and FW Services.

School Health Programme is one of the important National Health Programme. Under this programme students from 1 to 10th standards are medically examined and are treated, Students are given D.T and 2 booster dose of T.T immunization. Teachers are trained on First Aid treatment and on other health programmes also.

As teachers are trained on First Aid treatment, it is necessary to provide First Aid kits to schools as children need treatment for injuries and other minor ailments during school hours.

Education department in collaboration with Health department is organizing every year, "Suvarna Arogya Chaitanya" - school health check up programme from 2007 onwards. Student from 1-10th class studying in government schools where majority of the students are from economically weaker sections. During the medical examination several students suffering from severe problems are identified. They would need surgical corrections such as Congenital Heart diseases, heart septal defects, eye defects, ear/hearing defects, cancer treatment, orthopaedic problems. Due to their poor economic status the parents are forced to neglect their ailment. Hence under NRHM medical assistance to such children is planned. The Health society at the state level can be authorized to sanction reimbursement to the students who fall under BPL category and who are not insured under any health scheme.

During health check up camps conducted at schools every year out of 80 lakh children screened for various ailments 10% of them will have medical problems and out of which nearly .0.5% from severe defects which need treatment at super speciality hospitals. The treatment is costly hence parents do not get their children the treatment. Cash assistance in the form of treatment is required.

Total cost Rs.250 lakhs

GOI approved for Rs.250.00 lakhs

7.3 Specialists camps at Taluka and District hospitals:

Health camps are planned at every taluk hospital (149 hospitals) and at 24 district hospitals every month to provide quality health care for the rural population who need checkups by specialists are made available at the hospitals. The dates would be pre planned and the taluka camp precedes district camps. The patients who need more specialized treatment will be referred to districts hospitals. Telemedicine facilities will be made available at the camps. (esp. district camps)

Budget:

- 149 taluka camps at Rs.15000 each x 12 months = Rs.268.20 lakhs
- 24 district camps at Rs. 50000 each x 12 months = Rs.144.00 lakhs

Cost: Rs.412.20 lakhs

GOI approved for Rs. 412.00 lakhs

7.4 Yashaswini / insurance coverage for very high risk ANC cases :

HIV infection among the pregnant women is one of the major public health problem during the recent years. This problem was attempted to be addressed under general MCH services without any appreciable care and support as was desired. Hence it has been proposed for providing insurance/Yashavini coverage for very high risk pregnancies @ Rs.6000/- per case for 6,000 cases total of 360 lakhs.

Cost: Rs. 360 lakhs

GOI approved for Rs. 360.00 lakhs

Budget requirement of Karnataka under NRHM PIP for 2008-09

Budget head (Rs. In lakhs)

Sl. No	Activity	NRHM flexi pool	RCH flexi pool	RCH Addl	NGO division	FW -2211	Non communicable diseases (Prevention and control of diabetes, CVD & Stroke)	Immunisation	NPPCD	Disease control programmes	State Investment	Grand Total
1	Infrastructure strengthening	5433.58									7001.00	5433.58
2	Man power	989.80	6192.06									7181.86
3	Drugs			1700.00								1700.00
4	Equipments	1.80	539.35									541.15
5	Programme Mangement	668.40	287.82									956.22
6	RCH II interventions including JSY and Family Planning	100.00	11274.84			18000.00						29374.84
7	PPP NGO Intervention				160.00							160.00
8	Additionalities to NRHM	11283.65	3238.60								400.00	14522.25
10	Immunisation	-	-					979.25				979.25
11	NPPCD	11.00							125.00			136.00
12	Disease control programmes	304.00								5265.34		5569.34
13	Non communicable diseases (Prevention and control of diabetes, CVD & Stroke)						49.16					
	Total	18792.23	21532.67		160.00	18000.00	49.16	979.25	125.00	5265.34	7401.00	72304.65

(Grand total is excluding 1700 lakhs for drugs)

Note:

GOI support shown in 08-09 Rs.424.00 Crores

15% hike from GOI = Rs.63.60 Crores

Sub Total	RS. 487.6	Crores
State investment @ 15%	Rs. 74.01	Crores
Total	Rs. 561.61	Crores
Fund balance with state	Rs. 139.00	Crores
Total Resource	Rs. 700.61	Crores
Net deficit	Rs. 22.44	Crores

Deficit= around 3.0% of resources

GOI has approved for total amount of Rs.691.39 crores as its resources for Karnataka for 2008-09

Chapter –8
TOTAL BUDGET FOR THE YEAR 08-09
Budget Summary

Sl. No.	Activity	Unit physical Qty	Unit cost	Source of funds												Cost (in lakhs)
				NRHM Flexi pool	RCH Flexi pool	Addl. To RCH (separate funds from GOI)	NGO Division	Non communicable diseases (Prevention and control of diabetes, CVD & Stroke)	State budget	Part C-Immunisation programme	NPPCD	FW-2211	CSS	DCP	Total
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
A	**Infrastructure strengthening**														
1	Rent for sub centers	2893	0.005	173.58											
2	Grant for ANM training centers.	9	40	360.00											
3	Upgradation of taluk hospital in backward taluks identified under Dr. Nanjundappa committee report (look in page no. 8 for remaining works)	1							500.00						
4	Construction of PHCs	2	50	100.00											
5	Upgradation of PHCs	2	50	100.00											
6	Spillover civil Works of the year 2007-08 (53 Tqhs + 36 CHCs + 12 DHS + 200 SCs)	101	-	3800.00											
7	Up gradation of District hospitals to IPHS (Cost of equipments under NRHM for identified 7 DHs only)	7		400.00											
8	Construction of 44 CHCs & 53 tq. Hospitals	97							6501.00						
9	EMRI			500.00											
	Sub Total			**5433.58**											

Chapter –8
TOTAL BUDGET FOR THE YEAR 08-09
Budget Summary

Sl. No.	Activity	Unit physical Qty	Unit cost	Source of funds (Cost in lakhs)												
				NRHM Flexi pool	RCH Flexi pool	Addl. To RCH (separate funds from GOI)	NGO Division	Non communicable diseases (Prevention and control of diabetes, CVD & Stroke)	State budget	Part C-Immunisation programme	NPPCD	FW-2211	CSS	DCP	Total
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
B	**Manpower**														
1	**Sub centre**														
a	Appointment of ANMs / staff nurse / retd. ANM for SCs	1744	0.06		1255.68										
b	2nd ANM/ staff nurse at SCs in 6 C districts (from 2nd qtr)	1500	0.06	810.00											
2	**PHC**														
a	PHC Medical Officers on contract. 100 B/F from RCH I	100	0.17		204.00										
b	2 SNs for 399 (most backward taluks), 1 SN for 347 (more bakward taluk) and 1066 SNs for gap to convert total of 1187 PHCs to make into 24 x 7 and 163 SNs in 6 C category districts	2374	0.07		1994.16										
c	Asst. to Staff nurse for night stay and to assist her in cleaning the premises after deliveries	1187	0.01		1424.40										
3	**CHC**														
a	2 Staff nurses for 220 FRUs	440	0.07		369.60										
b	Specilists for Taluk hospitals	149	0.5		894.00										
c	Lab technician	108	0.03800		50.22										

Chapter –8
TOTAL BUDGET FOR THE YEAR 08-09
Budget Summary

Sl. No.	Activity	Unit physical Qty	Unit cost	Source of funds											Cost (in lakhs)
				NRHM Flexi pool	RCH Flexi pool	Addl. To RCH (separate funds from GOI)	NGO Division	Non communicable diseases (Prevention and control of diabetes, CVD & Stroke)	State budget	Part C-Immunisation programme	NPPCD	FW-2211	CSS	DCP	Total
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
4	**For Janani Suraksha Vahini**														
a	Driver for ambulances (149X2)	298	0.05000	179.80											
	Sub Total			**989.80**	**6192.06**										**7181.86**
C	**Drugs**														
	RCH kits(A & B)					1000.00									
2	IFA for ANC cases	12 lakhs	-			440.00									
3	IFA Small	23 lakhs	-			100.00									
4	Vitamin A					160.00									
	Sub Total					**1700.00**									**1700.00**
D	**Equipments**														
1	SUB center equipments				380.00										
2	MVA	646	0.012		7.75										
3	IUD kits				50.00										
4	CHC Oxygen concentrate	127	0.8		101.60										
5	Mobile Phones (recurring cost)	149	0.01200	1.80											
	Sub Total			**1.80**	**539.35**										**541.15**
E	**Programme Management**														
1	BPMU	176		508.00											
2	SPMU				42.57										
3	DPMU				208.00										
4	Stengthening of financial system			30.40											
5	State consultants under RCH 2 PROGRAMME	5	0.25		15.00										
6	Public health specialists to	29	0.20000	69.60											

Chapter –8
TOTAL BUDGET FOR THE YEAR 08-09
Budget Summary

Sl. No.	Activity	Unit physical Qty	Unit cost	Source of funds											Cost (in lakhs)
				NRHM Flexi pool	RCH Flexi pool	Addl. To RCH (separate funds from GOI)	NGO Division	Non communicable diseases (Prevention and control of diabetes, CVD & Stroke)	State budget	Part C-Immunisation programme	NPPCD	FW-2211	CSS	DCP	Total
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
7	Hospital Management specialists for 17 district hospital and 4 general hospitals	24	0.20000	50.40											
8	Institutional Strengthening				22.25										
9	Programme Management unit under RNTCP			10.00											
	Sub Total			**668.40**	**287.82**										**956.22**
F	**Part A RCH II programme**														
1	Family Planning	4 lakhs			2200.00										
2	JSY	5 lakhs			3500.00										
3	Maternal health,				3100.23										
4	Incentive to trained MBBS doctors and TA/DA for MTs for EMOC training and LSAS				78.60										
5	Child health,				300.16										
6	Adolescent Health				40.00										
8	Urban RCH				146.80										
9	Tribal RCH & vulnerable				280.40										
10	Support for Haemophilia pateints														
11	PPP - MNGO scheme						160.00								

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Chapter –8
TOTAL BUDGET FOR THE YEAR 08-09
Budget Summary

Sl. No.	Activity	Unit physical Qty	Unit cost	Source of funds											Cost (in lakhs)
				NRHM Flexi pool	RCH Flexi pool	Addl. To RCH (separate funds from GOI)	NGO Division	Non communicable diseases (Prevention and control of diabetes, CVD & Stroke)	State budget	Part C-Immunisation programme	NPPCD	FW-2211	CSS	DCP	Total
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
12	Training				903.50										
13	IEC			100.00											
14	BCC				371.90										
15	M&E				271.05										
16	Quality Assurance Programme	6	8.00		48.00										
17	PNDT				34.20										
18	Family Welfare (2211 - treasury mode)											18000.00	18000.00		
	Sub Total			**100.00**	**11274.84**		**160.00**					**18000.00**	**18000.00**		**47434.8**
G	**Part B Additionalities to NRHM**														
1	Upgradation of Taluka hospitals to FRU's	37	20.00	740.00											
2	Blood storage for FRUs upgraded previous year	40	2.00		80.00										
3	Boyles apparatus	54	2.00		108.00										
4	Adult resuscitation kit	54	0.40		21.60										

Chapter –8
TOTAL BUDGET FOR THE YEAR 08-09
Budget Summary

Sl. No.	Activity	Unit physical Qty	Unit cost	Source of funds (Cost in lakhs)												
				NRHM Flexi pool	RCH Flexi pool	Addl. To RCH (separate funds from GOI)	NGO Division	Non communicable diseases (Prevention and control of diabetes, CVD & Stroke)	State budget	Part C-Immunisation programme	NPPCD	FW-2211	CSS	DCP	Total
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
5	ASHA / link workers training + incentives + ASHA support system. ASHA training only is booked in NRHM). Linkworkers to be selected in 7 northern districts			771.00	3029.00										
6	Additional AYUSH doctors for single doctor PHCs in most, more and backward taluks	584	0.113	791.90											
7	AYUSH drugs for all AYUSH doctors working under NRHM	859	0.28	240.00											
9	Untied fund for SC	8143	0.10	814.30											
10	Untied fund and Maintainance grant for PHC	2195	0.75	1646.25											
11	Untied fund and Maintainance grant for CHC	325	1.50	487.50											
12	Maintainance grants for maternity hospitals under Dharwad corporation	1	50.00	50.00											
13	Arogya raksha samithi at CHC	325	1.00	325.00											
14	Arogya raksha samithi at District Hospital	24	5.00	120.00											
15	Untied fund for Village Health & Sanitation Commitees	20000	0.10	2000.00											

Chapter –8
TOTAL BUDGET FOR THE YEAR 08-09
Budget Summary

Sl. No.	Activity	Unit physical Qty	Unit cost	Source of funds											Cost (in lakhs)
				NRHM Flexi pool	RCH Flexi pool	Addl. To RCH (separate funds from GOI)	NGO Division	Non communicable diseases (Prevention and control of diabetes, CVD & Stroke)	State budget	Part C-Immunisation programme	NPPCD	FW-2211	CSS	DCP	Total
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
16	Capacity building for members of VHSCs	20000	1000.00	200.00											
18	Mobile Medical Unit (Vehicle +Equipment+ Maintanance +Manpower)	26	12.000	312.00											
19	State health system resource centre	1	100.00	100.00											
20	Deputing 10 candidates for Diplomo in Public Health Management couse at Sevegrama	10	1.35	13.50											
21	Tele medicine			50.00											
22	District untied funds			200.00											
23	State Untied			400.00											
H	**INNOVATIONS**														
1	Madilu kits for BPL/SC/ST who deliver in government institutions			1000.00					400.00						
2	School health programme			250.00											
	Specialists' camps at Taluk every month	149	0.15	268.20											
3	Specialists' camps at district hospitals every month	24	0.5	144.00											
4	Yashaswini / insurance coverage for very high risk ANC cases			360.00											
	Sub Total			**11283.65**	**3238.60**				**400**						**14922.3**

Chapter –8
TOTAL BUDGET FOR THE YEAR 08-09
Budget Summary

Sl. No.	Activity	Unit physical Qty	Unit cost	Source of funds											Cost (in lakhs)
				NRHM Flexi pool	RCH Flexi pool	Addl. To RCH (separate funds from GOI)	NGO Division	Non communicable diseases (Prevention and control of diabetes, CVD & Stroke)	State budget	Part C-Immunisation programme	NPPCD	FW-2211	CSS	DCP	Total
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
I	PART C														
	IMMUNIZATION (PPI)									979.25					0.00
	Sub Total									**979.25**					**979.25**
J	PART D														
1	RNTCP			0										######	
2	NPCB			0									50.00	######	
3	NLEP			0										158.33	
4	NIDDCP			160.00									10.00	22.00	
5	IDSP			139.00									66.00	406.75	
6	NVBDCP cash assistance			5.00									100.00	395.26	
	NVBDCP in kind (commodities)			0										400.00	
7	NPPCD			11.00							125.00				
8	Communicable disease control programme			0										80.00	
9	Non communicable diseases (Prevention and control of diabetes, CVD & Stroke)							49.16							
	Sub Total			**315.00**				**49.16**			**125.00**		**226.00**	**5265.3**	**5980.5**

Chapter –8
TOTAL BUDGET FOR THE YEAR 08-09
Budget Summary

SL No.	Activity	Unit physical Qty	Unit cost	Source of funds (Cost in lakhs)												
				NRHM Flexi pool	RCH Flexi pool	Addl. To RCH (separate funds from GOI)	NGO Division	Non communicable diseases (Prevention and control of diabetes, CVD & Stroke)	State budget	Part C-Immunisation programme	NPPCD	FW-2211	CSS	DCP	Total
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
K	**PART E**														
1	Nutrition (W&CD Dept.)								28326.00						
2	Water Supply (RWS Dept.)								30273.00						
3	Sanitation (RDPR Dept.)								63249.00						
	Sub Total								**121848.00**						
L	**Additionalities under State budget**														
1	Upgradation of PHCs, CHCs, GHs								2000.00						
2	EMRI								3750.00						
3	Upgradation of taluk hospital in backward taluks identified under Dr. Nanjundappa committee report (look in page no. 8 for remaining works)								2000.00						
	Sub Total								**7750.00**						
	Grand Total			**18792.23**	**21532.67**		**160.00**	**49.16**	**7401.00**	**979.25**	**125.00**	**18000.00**		**5265.34**	**72304.65**

Note: **Under State budget only investment on health (Rs.7401.00 lakhs) only is taken into consideration for grand total in consolidated budget.**

GOI approved PIP

NATIONAL RURAL HEALTH MISSION

KARNATAKA – RECORD OF PROCEEDINGS – 2008 – 09

Record of Proceedings of the National Programme Coordination Committee (NPCC) held under the Chairmanship of Shri G.C.Chaturvedi, Additional Secretary and Mission Director, NRHM for approval of NRHM Prgoramme Implementation Plan dos Karnataka for the year 2008-09

A meeting of the NPCC of NRHM was held under the Chairmanship of Shri G.C. Chaturvedi, AS & MD, NRHM, to approve the PIP of Karnataka on 18th March, 2008. The list of members who attended the meeting is placed at Annex.-I. The NPCC meeting was convened after the Pre-Appraisal meeting for the State with written and oral comments provided to the State to modify the proposal before the NPCC.

It was clarified to the States that the proposal of the State under NRHM 2008-09 would comprise of the following resources.

(A) Likely unspent (Committed and uncommitted) balance under NRHM in the State on 1st April, 2008.

(B) Resource Envelope for the state under NRHM from the Ministry of Health and Family Welfare, GOI, as communicated by the Ministry to the States.

(C) 15% State contribution to NRHM made as a grant to the State Health Society. The 15% contribution will be against the overall Resource envelope of NRHM listed at "B" above.

(D) 10-15% over and above A+B+C, above, assuming some carry over of works at the end of the financial year 2008-09.

Based on the above principle, the allocation for the State is as follows:

Unspent Balance under NRHM on 1.4.2008.	As per FMR for the quarter ending March 2008. Approximate assessments of unspent/uncommitted funds under NRHM in the State has been incorporated in respective programmes.
GOI Resource Envelope for 2008-09 under NRHM.	Rs. 424.65 Crores
15% State Share	Rs. 65 Crores
10-15% over and above the resources	Rs. 75 Crores
Total	Rs. 564.65 Crores

The tentative Resource Pool wise break up of total NRHM resources indicated to the State for preparation of PIP was as follows:

Sl. No.		Likely Unspent/Uncommitted balance on 1.4.2008	GOI Resource Envelope under NRHM
1	RCH Flexible Pool	18.79	104.69
2	NRHM Flexible Pool	106.00	91.20
3	Immunization (under RCH Flexible Pool)	1.95	
4	NVBDCP	N.A.	7.28
5	RNTCP	N.A.	12.67
6	NPCB	N.A.	16.00
7	NPPCD	N.A.	-
8	IDSP	N.A.	1.31
9	NLEP	N.A.	1.53
10	IDD	N.A.	0.24
11	Direction & Admn. (Treasury route)	N.A.	179.73
12	PPI Oper. Cost		9.99
13	15% State share (Could be against any activity as the State desires)		65.00
14	10-15% Over Planning		75.00
	Total	**126.74**	**564.65**

TOTAL RESOURCES FOR 2008-09 – Rs. 691.39 Crores.

Based on the State's PIP and deliberations thereon the Plan for the State is approved as per the details of Annexure II (RCH Flexible Pool), Annexure III (NRHM Flexible Pool), Annexure-IV (Immunization) & Annexure-V (National Disease Control Programmes). The unspent/uncommitted figures have been taken as indicated by States. Any modification in that figure will have implications for the size of the PIP. The activities from uncommitted recourses will reduce to the extent that there is lower than the indicated amount with the State. It is also clarified that core activities for decentralized management of the health system like untied grants to Village Health and Sanitation Committees, Sub Centres, PHCs, CHC, District Hospitals, RKS grants have to be fully provided for and it is not permitted to divert any savings from these core activities under NRHM.

The following general conditions will apply:-

1. All posts under NRHM are an contract and based on local criteria. These should be done by the Rogi Kalyan Samiti/District Health Society. Residence at place of posting is mandatory. All such appointments are for a particular institution and non transferable.

2. Blended payments comprising of a base salary and a performance based component, should be encouraged.
3. State Government must fill up its existing vacancies against sanctioned posts, preferable by contract.
4. Transparent transfer and career progression systems should be implemented in the State, for established cadres.
5. Delegation of administrative and financial powers should be completed during the current financial year.
6. State shall set up a transparent and credible procurement and logistics systems on the lines of the Tamil Nadu Medical Services Corporation. State agrees to periodic procurement audit by third party to ascertain progress in this regard.
7. The State shall undertake institution specific monitoring of performance of Sub Centre, PHCs, CHCs, DHs, etc.
8. The State shall operationalize an on-line HMIS in partnership with MOHFW.
9. The State shall take up a massive capacity building exercise of Village Health and Sanitation Committees, Rogi Kalyan Samitis and other community/PRI institutions at all levels.
10. The State shall ensure regular meetings of all community Organizations/District/ State Mission with public display of financial resources received by all health facilities.
11. The State Govts. shall also make contributions to Rogi Kalyan Samitis besides seeking public donations/charges wherever feasible.
12. The State shall endeavor to bring the Budget of Health facility under the supervision of Rogi Kalyan Samiti/Hospital Mangement Committee, etc.
13. The State shall prepare Essential Drug lists of generic drugs and Standard treatment Protocols, and give it wide publicity.
14. The State shall focus on the health entitlements of vulnerable social groups like SCs, STs, OBCs, Minorities, Women, migrants etc.
15. The State shall ensure timely performance based payments to ASHAS/Community Health Workers.
16 Incentives for ASHAs will be booked under the respective programmed.
17. The State shall encourage in patient care and fixed day services for family planning.
18. The State shall ensure effective and regular organization of Monthly Health and Nutrition Days, including record-keeping (to monitor utilization of services) and linking them to regular services for antenatal care, postnatal care, immunization etc.
19. All performance based payments/incentives should be under the supervision of Community Organizations (PRI)/RKS.
20. The State agrees to follow all the financial management systems under operation under NRHM and shall submit Audit Reports, FMRs, Statement of Fund Position, as and when they are due. State also agrees to undertake Concurrent Audit of District Health Societies and periodic assessment of the financial system.

21. The State agrees to fast track physical infrastructure upgradation by crafting State specific implementation arrangements. State also agrees to external evaluation of its civil works programmes.

22. The State Government agrees to co-locate AYUSH in PHCs/CHCs, wherever feasible.

23. 15% of the State share would have to be credited to the account of the State Health Society.

24. The state should improve implementation of JSY by ensuring that:

    a) Payment is made to the beneficiary at the time of delivery through bearer cheque;

    b) Referral package is as per guidelines;

    c) Monitoring of JSY is as per directives of GOI;

    d) Grievance redressal mechanism for JSY is set up at the local level;

    e) Quality of services for deliveries at public health facilities is monitored; private sector facilities are accredited and monitored;

    f) Two days stay after delivery is adhered to and newborn care essentials (counseling and basic equipment) are focused upon in the facilities;

25. The State Government shall ensure optimal utilization of funds under National Health programmes and for Disease Surveillance with appropriate support the NRHM for these programmes.

B. (Any State Specific Conditions/Observations)

Details about the Insurance scheme for high risk ANC mothers may be provided and the implementation may be started after approval for the same separately.

SUMMARY APPROVAL

(Details provided in respective Annexes)

	Scheme / Programme	**Approved Amount (In Rs. Crores)**
1.	RCH Flexible Pool	Rs. 210.19
2.	NRHM Flexible Pool	Rs. 185.47
3.	Immunization (from the RCH Flexible Pool)	Rs. 9.83
4.	NVBDCP	Rs. 8.42
5.	RNTCP	Rs. 9.21
6.	NPCB	Rs. 13.08
7.	NIDDCP	Rs. 0.24
8.	IDSP	Rs. 1.35
9.	NLEP	Rs. 195
10.	Infrastructure Maintenance (Treasury Route)	Rs. 179.73
	TOTAL	**Rs. 619.47**

NOTE:

1. Total Resource Available includes the unspent/uncommitted balance under programmes, over and the Resource for the year.

ANNEX – I

Attendance sheet for the meeting of National Programme Coordination Committee held on 18.3.2008 to consider the PIPs 2008-09 of Karnataka

Sl. No.	Name & Designation	Address	Telephone No.
1.	Ms. Renuka Patnaik	NIHFW	261607773
2.	Sh. S.C.Garg	NIHFW	26165909
3.	Dr. R.S. Sharma	NVBDCP	23972884
4.	Shri G.C. Chaturvedi, AS&MD	Ministry of Health & FW	23061451
5.	Shri Amarjeet Sinha, JS (AS)	"	23062157
6.	Ms. Aradhna Johri, JS (AJ)	MoHFW	
7.	Shri P.K.Aggarwal, Dir. (NRHM)	"	23062205
8.	Dr. Ravinder Singh, Dir.	MoHFW	23062108
9.	Dr. G.Shivaram, Project Dir.	IDSP	9844186122
10.	Dr. R.L.Ichhupujani	NPO – IDSP	23932290
11.	Dr. Asha Thomas, Director	"	23062426
12.	Dr. I.P.Kaur, (DC (Trg.)	MoH&FW	
13.	Shri S.K.Sikdar		
14.	Shri B.K.Tiwari, Adv. Nutrition	"	23062113
15.	Dr. Sandeep Sachdeva	NPCB, MoHFW	
16.	Dr. A. Raghu, Addl. Adv. (Ayush)	Deptt. of AYUSH	
17.	Ritu Priya	NHSRC	9313350186
18.	Dr. Naresh Goel, AC (USP)	MoHFW	9819534262
19.	Dr. D.K. Mangal		9810783023
20.	Mrs. Archana Varma, DS (AV)	MoHFW	
21.	Dr. A.K.Puri, DADG	MoHFW	23061869
22.	Shweta Verma, PMSG	A-280, New Friends Colony	
23.	Dr. Manisha Malhotra, AC (MH)	MoHFW	
24.	Dr. Sunil Kaparde, DC (ID)	MoHFW	

Sl. No.	Name & Designation	Address	Telephone No.
25.	Dr. H.C. Ramesh, State Nodal Officer NPDCD	Anandarao Circle, Bangalore	22874196
26.	Dr. V.Dinamani, State T.B. Officer	T.B.Centre, SR Ngr, Bangalore	9845393010
27.	Dr. Annapurna, J.O.	Bangalore	22249364
28.	Dr. P.Vasudeva Rao, JD	Dte. of H&FW Services, Bangalore	9880285198
29.	Dr. B.Vasudevamurthy, DD, IDSP	Bangalore	9880024329
30.	Dr. K.Jagaroop Singh, DD	Dte. of Health, Bangalore	9449051637
31.	Dr. H.Siddaiah, DD (Leprosy)	DHS, Karnataka	08022351568
32.	Shri Narayana	State Health Society, Karnataka	08022870224
33.	Dr. P.K.Srinivas, Consultant	Karnataka	9448247129
34.	Dr. Mohan Roy, PD, RCH	Govt. of Karnataka	9448247129
35.	Shri M.Madan Gopayl, Secy. H&FW	Govt. of Karnataka	22255324
36.	Nilaya MD, NRHM	Govt. of Karnataka	9845100311

ANNEX – II

Approval under RCH Flexible Pool

Activity Proposed	Amount proposed (Rs. in lakhs)	Amount Approved (Rs. in lakhs	Remarks
Appoints of ANM/Staff Nurse	1255.00	1255.00	Approved
PHC medical officers on contract	204.00	204.00	Approved
Two staff nurse for 399 most backward taluka) & one SN for 347 (more backward taluka)	1994.00	1994.00	Approved
Asst. to Staff Nurse for night stay and to Assist her in cleaning the premises after delivery	1424.00	1000.00	Approved only at places 24x7 has been operationalised
Two staff nurse for 220 FRUs	369.00	369.00	Approved
Specialists for taluka hospitals	894.00	894.00	Approved
108 Lab Tech.	50.00	50.00	Approved
Sub-centre equipment	380.00	380.00	Approved
MVA	07.00	07.00	Approved
IUD Kits	50.00	50.00	Approved
CHC Oxygen Concentrator	101.00	100.00	Approved
SPMU	43.00	40.00	Approved
DPMU	208.00	200.00	Approved
State Consultant under RCH	15.00	15.00	Approved
Institutional Strengthening	22.00	20.00	Approved
Family Planning	2200.00	3500.00	Approved
JSY	3000.00	3000.00	Approved
Maternal Health	3100.00	2376.00	Approved
(i) Mobility Support to ANMs	195.00	195.00	Approved, only in SCs located in remote & tribal areas
(ii) Incentive for ANMs for high risk & HIV cases	686.00	660.00	Approved
(iii) Awards to ANMs	09.00	09.00	Approved
(iv) Remote area allowances for doctors & staff nurses	1611.00	1300.00	Approved for performance based incentive
(v) Incentives for night deliveries	330.00	0.00	Not approved
(vi) Stationery printing	100.00	100.00	Approved as a part of management support

Activity Proposed	Amount proposed (Rs. in lakhs)	Amount Approved (Rs. in lakhs	Remarks
(vii) Mobility support for PHCs	100.00	100.00	Approved
(viii) Best doctor & staff nurse award	05.00	05.00	Approved
(ix) ART	50.00	0.00	Not approved, may be taken from SACS
(x) Opportunistic infection	06.00	0.00	
(xi) Maternal death audit	07.00	07.00	Approved
Incentive to trained MBBS doctors & TA/DA for EMOC training	78.00	78.00	Approved
Child Health	300.00	300.00	
Adolescent Health	40.00	40.00	Approved
Urban RCH	147.00	147.00	Approved
Tribal RCH & Vulnerable population	280.00	280.00	Approved
Training	903.00	850.00	Approved
BCC	371.00	325.00	Approved
M&E	271.00	225.00	Approved
Quality Assurance	48.00	48.00	Approved
PNDT	34.00	34.00	Approved
Blood storage at FRUs	80.00	80.00	Approved
Boyle's Apparatus	108.00	108.00	Approved
Adult resuscitation Kit	21.00	21.00	Approved
ASHA link workers	3029.00	3029.00	Approved
Total	**21026.00**	**21019.00**	

ANNEX – III

Approval under NRHM Mission Flexible Pool

Activity Proposed	Amount proposed (Rs. in lakhs)	Amount Approved (Rs. in lakhs	Remarks
Rent for sub-centre	173.00	173.00	Approved
Grant for ANM training centres	360.00	360.00	Approved
Construction of PHCs	100.00	100.00	Approved
Upgradation of PHCs	100.00	100.00	Approved
Spill over civil work for last year (53 taluka & 36 CHCs + 12 DHs + 200 SCs	3800.00	3800.00	Approved
Upgradation of 7 DHs to IPHs	400.00	400.00	Approved
EMRI	500.00	500.00	Approved
Second ANM/staff nurse at SCs only in 6 backward districts	810.00	810.00	Approved
2 Drivers each for Ambulances 149 CHCs	179.00	179.00	Approved as a part of programme management cost
Mobile phones recurring cost	02.00	02.00	Approved as a part of programme management cost
BPMU	508.00	508.00	Approved as a part of programme management cost
Strengthening of financial system	30.00	30.00	Approved
Public health specialists in districts	69.00	69.00	Approved as a part of programme management cost
Hospital management specialist for 17 DHs + 4 General Hospitals	50.00	50.00	Approved as a part of programme management cost
IEC	100.00	100.00	Approved
Upgradation of Taluka hospitals to FRUs	740.00	740.00	Approved
Training for ASHA/link workers	771.00	771.00	Approved
Addl. AYUSH doctors for single doctor PHC for most backward talukes	791.00	791.00	Approved

Activity Proposed	Amount proposed (Rs. in lakhs)	Amount Approved (Rs. in lakhs	Remarks
AYUSH drugs	240.00	0.00	Not approved to be sought form D/o AYUSH
United fund to SCs	814.00	814.00	Approved
United funds + maintenance grant to PHCs	1646.00	1646.00	Approved
United funds + maintenance grant to CHCs	487.00	487.00	Approved
Maintenance grant to maternity hospitals in Dharwar Corporation	50.00	50.00	Approved
RKS at CHCs	325.00	325.00	Approved
RKS at DHs	120.00	120.00	Approved
VHSC	2000.00	2000.00	Approved
Capacity Building for members of VHSC	200.00	200.00	Approved
Mobile medical Unit	312.00	312.00	Approved
State HSCRC	100.00	100.00	Approved
Diploma in Public Health – 10 candidates	13.00	13.00	Approved
Tele-medicine	50.00	50.00	Approved
District untied funds	200.00	200.00	Approved
State untied funds	400.00	200.00	Approved
Innovative scheme – Medilu kits for SC/ST BPL families	1000.00	1000.00	Approved
School Health Programme	250.00	250.00	Approved
Specialist camps at Talukas every months	268.00	268.00	Approved
Specialist camps at DHs every months	144.00	144.00	Approved
Yasaswini Insurance coverage for high risk ANC cases	360.00	360.00	Approved as proposed for the current year
NIDDCP	160.00	160.00	Approved provided such items not available under respective programmes
Programme management Unit under RNTCP	10.00	10.00	
IDSP	139.00	139.00	
NVBDCP	05.00	05.00	
NPPCD	11.00	11.00	
Total	**18787.00**	**18547.00**	

ANNEX – IV

Approved under Immunization

Activity Proposed	Amount proposed (Rs. in lakhs)	Amount Approved (Rs. in lakhs	Remarks
Mobility support	16.00	16.00	Approved
Alternative Vaccine Delivery	240.00	240.00	Approved
Focus on slum & underserved areas	92.00	92.00	Approved
Mobilisation through AWW	360.00	360.00	Approved
Training & review	89.00	89.00	Approved
Computer assistance district + State	35.00	35.00	Approved
POL for vaccine delivery	15.00	15.00	Approved
Printing of forms & guidelines	100.00	91.00	Approved
Cold Chain	45.00	45.00	Approved
Total	**992.00**	**983.00**	

ANNEX – V

Approved under National Disease Control Programme

RNTCP

Activity Proposed	Amount proposed (Rs. in lakhs)	Amount Approved (Rs. in lakhs	Remarks
Civil Works	26.00	21.00	Approved
Lab. Materials	93.00	88.00	Approved
Honorarium	27.00	12.00	Approved
IEC	64.00	29.00	Approved
Equipment Maintenance	28.00	13.00	Approved
Training	127.00	46.00	Approved
Vehicle Maintenance	56.00	50.00	Approved
Vehicle hiring	23.00	30.00	Approved
NGO/PPP Support	28.00	13.00	Approved
Misc.	89.00	58.00	Approved
Contractual Services	476.00	476.00	Approved
Printing	84.00	28.00	Approved
Medical Colleges	123.00	50.00	Approved
Procurement of vehicles	02.00	05.00	Approved
Procurement of equipment	03.00	02.00	Approved
Total	1249.00	921.00	

NVBDCP

Sl. No.	Activity Proposed	Amount proposed (Cash + Commodity) (In Rs. Lakhs)	Amount Approved (Cash assistance) (In Rs. Lakhs	Amount Approved (Commodity assistance) In Lakhs	Remarks
1.	Malaria	345.00	0.00	345.00	Approved for cash assistance + likely unspent as on 1.04.08 i.e. Rs. 3.30 crore
2.	GFATM	0.00	0.00	0.00	
3.	World Bank (including training & IEC)	101.00	53.00	48.00	
4.	MPW (Male)	112.00	112.00	0.00	
5.	Kala-azar	0.00	0.00	0.00	
6.	ELF	115.00	115.00	0.00	
7.	J.E.	37.00	37.00	0.00	
8.	Dengue & Chikungunya	123.00	123.00	0.00	
	Total	842.00	440.00	402.00	

IDSP

Activity Proposed	Amount proposed (Rs. in lakhs)	Amount Approved (Rs. in lakhs	Remarks
Renovations of State & distict surveillance units & labs	40.00	0.00	Not approved
Lab. Equipment & Consumables	68.00	25.00	Approved
Operational Cost	52.00	10.00	Approved
Elisa reader & washer	115.00	70.00	Approved
IEC	30.00	10.00	Approved
16 Microbiologists	28.00	20.00	Approved
Office equipments + Laptop	41.00	0.00	Not approved
Mobile connection	08.00	0.00	Not approved
Training	20.00	10.00	Approved
NCD activitieds	04.00	0.00	Not approved
Total	406.00	135.00	

NPCB

Activity Proposed	Amount proposed (Rs. in lakhs)	Amount Approved (Rs. in lakhs	Remarks
Extension of eye care unit in NGO sectors in tribal areas – 4 units	100.00	25.00	Approved
5 Eye banks development	100.00	18.00	Approved for Recurring and Non-Recurring
Eye donation centres	05.00	06.00	Approved for Recurring and Non-Recurring
Vision centres in NGO sectors – 50	12.00	15.00	Approved at the rate of Rs. 25000/- per Centre
Equipments to medical colleges, DHs & Taluka hospitals	135.00	57.00	No equipment for med. Coll.
Cataract Surgeries	2062.00	1080.00	Payment allowed upto Rs. 750 per surgery
School eyes screening	55.00	30.00	Approved as a part of school health
IEC	0.00	10.00	Approved
Training	0.00	05.00	Approved

Activity Proposed	Amount proposed (Rs. in lakhs)	Amount Approved (Rs. in lakhs	Remarks
Recurring expenses	0.00	62.00	Approved for meeting salary, operational costs, contingency
Total	2469.00	1308.00	

NIDDP

Activity Proposed	Amount proposed (Rs. in lakhs)	Amount Approved (Rs. in lakhs	Remarks
Estt. of IDD Control Cell	06.00	06.00	Approved
Monitoring Lab	03.50	03.50	Approved
IEC	12.00	12.00	Approved
IDD survey	02.50	02.50	Approved
Total	**24.00**	**24.00**	

NLEP

Activity Proposed	Amount proposed (Rs. in lakhs)	Amount Approved (Rs. in lakhs	Remarks
Contractual Serviecs	10.00	10.00	Approved
Recurring expenses	42.00	40.00	Approved
Supportive medicines & materials	16.00	16.00	Approved
IEC	57.00	55.00	Approved
Training & review meetings	18.00	18.00	Approved
DPMR	05.00	05.00	Approved
Computers etc.	11.00	10.00	Approved
Total	**1.58.00**	**154.00**	

NPPCD

Activity Proposed	Amount proposed (Rs. in lakhs)	Amount Approved (Rs. in lakhs	Remarks
Capacity Building District Hospitals CHCs & PHCs	47.00	As per budget provided separately	As p[er guidelines provided separately
Training	35.00		
Screeming Camps	05.00		
SPU	06.00		
Microsurgery trg. For ENT sugeons + Consumables	05.00		
Total	**135.00**		

NATIONAL LEPROSY ERADICATION PRGORAMME

APPROVED ACTION PLAN FOR THE YEAR 2008-09 BASES ON NPCC – NRHM KARNATAKA

(Rs. in lakhs)

Sl. No.	Activity proposed	Amount proposesd	Amount Apprved	Remarks
1)	Contracual Services			
	State – BFO cum AO, DEO, SMO, Administrative Assistant, Driver	12.43	12.43	
	District – Driver, TA/DA to SMO/Drivers			
2)	MDT Management	7.50	7.50	
	Honararium to ASHA			
3)	Office Expenses	5.32	5.32	
4)	Consumables	3.10	3.10	
5)	Capacity Building	17.40	17.40	
	4 days training of newly appointed MO & HW/HS			
	2 days refresher training of MO			
	5 days training of newly appointed Lab. Tech.,			
	2 days training of Private Practioners, RMP & Dermatologists			
6)	Communication for Behavioral Chage	50.00	50.00	
	Wall Painting, Rallies, Quiz, Folk Show, IPC workshop, Hoardings			
	Meetin of opinion leadrs, Half day sensitization of ASHA			
7)	POL/Vehicle operation & hiring	30.20	30.20	
	2 vehicles at state level & district level			
8)	DPMR	24.66	24.66	
	Supportive medicines, MCR foorwear, Aids and appliances, Lab. Reagents/equipment, Prining forms, Incentive to BPL patients for RCS, Support to Institutions for RCS			
9)	Urban Leprosy Control Programme			
10)	NGO – SET Schement	4.50	4.50	
11)	Review meeting & Workshop	1.00	1.00	
	TOTAL	**156.00**	**156.11**	
12)	Cash assistance	-	34.27	
	TOTAL	-	**190.8**	

NIDDCP – RECORD OF PROCEEDINGS (ROPs) UNDER NRHM

KARNATAKA

Sl. No.	Name of Activity	Allocation for 2008-09 in Rs. Lakhs)	Proposed by State Govt.	Remarks
1.	Establishment of IDD Control Cell	6.00	There is no proposal for NIDDCP in the PIP of Karnataka	They may modify the PIP as per allocation of the fund
2.	Establishment of IDD Monitoring Lab	3.50		
3.	Health Education and Publicity	12		
4.	IDD Surveys	2.50		
	Total	**24.00**		

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